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GENERAL MENTAL HEALTH PRACTITIONERS AS EAP NETWORK AFFILIATES: DOES EAP  
SHORT-TERM COUNSELING OVERLAP WITH GENERAL PRACTICE PSYCHOTHERAPY?

David A. Sharar, Ph.D.  
Research Scientist  
Chestnut Health Systems  
1003 Martin Luther King Drive  
Bloomington, IL 61701  
[dsharar@chestnut.org](mailto:dsharar@chestnut.org)  
(309) 820-3570 office  
(309) 820-3574 fax

## **ABSTRACT**

The Employee Assistance Program (EAP) field has identified the skills and knowledge needed to provide EAP as unique from other helping professions. The most prevalent model in the delivery of EAPs is the Affiliate Network, where EAP vendors contract with a network of independent behavioral health clinicians, or "Affiliates", to provide EAP services in a private office to employees and family members. What has not been systematically examined until this study is how Affiliates enrolled in EAP networks deliver short-term counseling in the context of EAP. This study examines how Affiliates utilize short-term counseling with EAP specific cases referred to Affiliates, as well as how short-term counseling in EAP duplicates or overlaps with "General Practice" counseling. A "one-time" survey was created using subject matter experts and deployed over the Internet as a Web-based survey. A "working population" of 3,000 EAP Affiliates was used as the sampling frame and a random sample of 400 was drawn, with 222 surveys completed (55% response rate). Findings indicate there has been significant "leakage" from General Practice counseling into EAP, or the degree to which EAP clients receive General Practice counseling, in the form of short-term intervention as opposed to traditional EAP specific services. There is currently not much contrast between EAP work and General Practice counseling, and the marginal differences reflect the nuances of benefit design (e.g. number of allowed sessions) and a shift among a segment of respondents towards using solution-focused counseling with EAP clients. Implications of these findings are discussed.

## *Introduction*

About 75% of American employers offer Employee Assistance Programs (EAPs) as a prepaid benefit to help workers (and their families) with a variety of personal problems that may have a negative effect on their job performance (Masi, 2004; EAPA, 2003, Sciegaj et al, 2001). EAPs are now a first entry point for over 100 million American workers seeking help and referrals for personal, family, and behavioral health concerns (Ensuring Solutions, 2006; Masi, 2004; EAPA, 2003). EAPs, which grew out of occupational alcoholism programs, once focused primarily on alcohol problems but have expanded their focus to include mental health, marital, family and “work-life” issues such as financial, legal, childcare, eldercare, adoption, and career counseling (Ensuring Solutions, 2006; National Business Group on Health, 2005; Masi, 2004).

The original EAPs were “internal” programs, meaning services were provided by staff or employees of the sponsoring organization, but today most services are provided by an external, outsourced vendor (Ensuring Solutions, 2006; Masi, 2004; Sciegaj et al, 2001; Hartwell, 1996, Kurzman, 1992). The vast majority of Fortune 500 companies contract with managed behavioral health organizations (MBHOs) to also provide EAP services (Ensuring Solutions, 2006; Oss, 2004). Large MBHO vendors that also offer EAP appear to dominate the EAP market, with the top six firms covering about 70% of the cumulative market share (Oss, 2004).

The Employee Assistance Program (EAP) field has identified the skills and knowledge needed to provide EAP as unique from other helping professions. The most prevalent model in the delivery of EAPs is the Affiliate Network, where primary EAP vendors contract with a network of independent behavioral health clinicians, or “Affiliates”, to provide EAP services in a private office to employees and family members. EAP vendors routinely form a contractual network of subcontract EAP Affiliates who are almost always licensed as social workers, professional counselors, psychologists, or marriage and family therapists (Ensuring Solutions, 2006; Masi, 2004; Sharar and White, 2001). This affiliate network model is highly popular and prevalent as it provides geographic accessibility in an efficient manner for employers with multiple, dispersed work sites and commuting employees (Masi, 2004; Collins, 2004). Services are delivered at an off-the-work-site, affiliate office location and thus may be perceived by the sponsoring

organization as discreet and efficient.

The majority of mental health clinicians who are based in a private, group, or agency practices have contracted with an EAP or managed behavioral health organization to join that vendor's affiliate network, or provider panel, and are thus eligible to receive cases from the referring vendor on an "as needed" or "on-demand" basis (Stout, Levant, Reed, and Murphy, 2001). These affiliates who perform EAP work on an "as needed" basis do not necessarily identify themselves as "EAP professionals", but rather as therapists, counselors, psychologists, or clinical social workers (EAPA, 2003). They may only understand and perform a portion of what constitutes EAP practice, or the "core technology".

The historic mission of helping impaired workers receive proper treatment and return to full workplace functioning may be partially replaced by using Affiliates to perform "short-term" counseling within EAP, whereby EAP may have evolved into a marginal or supplemental replacement for a more comprehensive outpatient mental health benefit. This means the employee's (or client's) concerns are handled exclusively within the EAP, when the assessed problem can be improved or resolved without a referral to an outside resource or specialty provider covered under an employer's health benefits plan. The short-term counseling model offers between one and six sessions with an Affiliate, compared to the traditional "assess and refer" model that offers between one and three sessions focused on problem identification and linkage to the most appropriate outside resources (Masi, 2004).

What has not been systematically examined is whether Affiliates enrolled in EAP networks deliver EAP intervention as conceptualized by the EAP field. This paper presents a specific portion of a larger study that examines if and how Affiliates apply the central concept of short-term counseling in EAP work to EAP specific cases. It specifically addresses how the practice of short-term counseling in EAP work with EAP clients, as practiced by Affiliates, duplicates or overlaps with counseling or psychotherapy when these same Affiliates handle cases as "General Practice" counselors or therapists.

#### *Significance of Short-term Counseling in EAP*

Short-term or brief counseling, intervention, treatment, or therapy is an important component in working with clients in the limited context of EAP when there is a considered expectation that short-term counseling can be helpful in approximately six or fewer sessions. When a referral is not indicated, or the act of therapeutically connecting a client with another helper or resource, then the EAP counselor can help to optimize outcomes within the scope and provisions of the EAP, thereby preventing a referral to the employer's benefit plan. Employers and their benefit consultants seem to embrace short-term counseling in EAP because it is practical, inexpensive, and "free" to employees and families (EAP services have no co-pays or deductibles). Masi (2004) notes that brief counseling usually focuses on a central theme or presenting problem and lasts between three and six sessions. In this manner, an employer who has aggressive case management in their medical or behavioral health benefits plan, with a focus on cost containment, may still offer an easily accessed short-term counseling benefit that may not be a part of a managed care arrangement (Masi, 2004). Short-term counseling is an "umbrella" term for a wide variety of approaches to therapy and casework with an emphasis on specific problem identification and direct intervention (Antonuccio and Lewinsohn, 2000). There are a variety of approaches and "practice movements" with short-term counseling, including cognitive-behavioral, solution-focused, eclectic/integrative, strategic family systems, and task-centered, to name a few. The "grab-bag" of diverse theories and models can be seen as a bewildering array of choices or a development that has opened us up to new methods and models of intervention (Reid, 2002).

It is often highly strategic and "solution-based", and less concerned about how problems arose than with factors sustaining problems and preventing change (de Shazer, 1988; Orford and Edwards, 1997). It also involves the deliberate and active use of the EAP counselor's ability to establish a rapid but strong working relationship with the client and to use it to determine, through dialogue with the client, what the focus will be (Masi, 2004). The task is to identify solvable problems, help the client set goals, and design interventions to achieve these goals (de Shazer, 1988; Orford and Edwards, 1997). Clients are viewed as persons with strengths and resources who can set their own directions and act as full collaborators who contribute expert knowledge of

themselves and their situations (Reid, 2002). Intervention is guided more by helping clients define and resolve their goals than by problem assessment or problem solving (Saleebey, 1996). There is less “pathologizing” of individuals and families and greater appreciation of the client’s resilience and strengths (Reid, 2002). Problems can be resolved through “taking action” and finding new ways of construing reality.

There is a vast amount of research that claim that interventions of a shorter duration are as effective and lasting as longer-term (Orford and Edwards, 1997). Despite the long list of “empirically supported” brief treatments, there is much to learn about how short-term counseling works, when, and for whom (Santisteban, Morales, Robbins, and Szapocznik, 2006). The conclusion that short-term counseling is generally effective and lasting begs the question of what then works best for what kinds of people with what kinds of problems? There is also a need to refine our understanding and practice of the successful dissemination of empirically supported brief treatments to the “front lines” of practitioners. There are still many challenges to selecting and training practitioners to sustain short-term counseling in a practice or agency over time, and to ensuring the fidelity needed to produce good outcomes.

### *Methods*

A “one-time” survey with 34 questions was created using subject matter experts drawn from the Editorial Board of the *Journal of Workplace Behavioral Health*. The survey was deployed in the fall of 2007 over the Internet in a Web-based format, an excellent alternative to the traditional mail out technique for several reasons, including convenience, rapid data collection, cost-effectiveness, ease of follow-up, and ample time to complete.

A “working population” of 3,000 EAP Affiliates that appears to be a microcosm of the general population was drawn with permission from “emindhealth” (EMH), a provider of behavioral health managed network services. In essence, EMH leases behavioral health provider networks to vendors and also supplies the “back office” support necessary to manage provider relationships. EMH provides network-related operations to EAP and MBH vendors on an

outsourced basis that includes EAP affiliate recruitment, credentialing, and referral/reimbursement processing.

Four hundred randomly selected potential respondents were drawn from the sampling frame of 3,000. Out of the 400, 222 surveys were completed and returned resulting in a SE of 3.5% and a response rate of 55%. The McNemar non-parametric test was used in the analysis since the same respondent compared General Practice cases to EAP cases. One open-ended question was analyzed through a process of content analysis and the identification of themes. Major threats to validity include the potential for desirability, unavailable information leading to “guessing”, memory problems, and no direct, naturalistic observations.

### *Findings and Conclusion*

This section begins with a description of Respondent Characteristics followed by findings related to the comparison of short-term counseling in EAP to General Practice. It specifically looks at choice of primary intervention theories or models, average number of sessions, determination of problem resolution within the EAP, and EAP overlap with General Practice Counseling. Findings are presented with written narrative and the reader is referred to figures. Following each narrative description of each finding, the author offers an interpretation of the finding and speculates on potential explanations or poses additional questions for further research.

### **Respondent Characteristics**

This part of the survey asked respondents about their highest educational level, the discipline under which they are licensed or certified, and their professional identity.

Licensing, certification, and educational level are the mechanisms used by EAP vendors to assure their client organizations (and clients) that practitioners enrolled in their affiliate networks are competent to deliver EAP services, and therefore these characteristics are germane. Eighty-one percent of respondents were master's-prepared practitioners with the remaining nineteen percent holding doctoral degrees. This supports the notion that master's-

trained individuals are seen as cost-efficient competition to the doctoral level clinician, especially in the absence of convincing evidence of differences in outcomes as a function of degree level.

Forty-two percent of respondents are licensed or certified as “Counselors” or “Mental Health Counselors” although their exact academic discipline is not known. The advent of licensure under a counseling title in most states over the past decade for master’s prepared graduates in clinical or counseling psychology, mental health counseling, or counselor education has created a new supply of licensed professionals doing EAP affiliate work. Social Work, with the licensed MSW, is the most common academic discipline represented at thirty-six percent in EAP affiliate work. Marriage and Family Therapy (or Marriage, Family, Child Counseling in some states) is the third highest category under which respondents are licensed or certified at eighteen percent. Psychologists, who have a doctoral-level standard to qualify for practice, represent twelve percent of respondents. Figure 1 shows the percent of licensed or certified disciplines within the sample.

Seventy-six percent of respondents see themselves as “general practitioners” in counseling or psychotherapy as opposed to “specialists” or “EAP professionals”. Thus, the vast majority of practitioners doing EAP work perceive themselves as resembling the “family practitioner” or “general internist” in medicine who diagnoses a broad range of medical issues, treats “garden variety” or typical problems, and refers to specialists for particular disease states or disorders requiring specialized expertise. The primary identity of “general practitioner” among respondents suggests they believe their training is broad enough to handle cases that are usual or typical with enough knowledge to know when to refer to a specialist for particular problems or disorders, populations, delivery settings, and intervention techniques. If EAP is in fact a distinguishing area of competence within a practice, and most respondents doing EAP work do not identify themselves as “EAP practitioners”, then the EAP field needs to grapple with an important question: Are general practice competencies, rather than distinctive EAP competencies, acceptable as the prime service orientation in EAP work?

## **Primary Theory or Model**

Respondents were asked about their primary theory or model used with General Practice versus EAP clients that use only short-term counseling within the EAP setting. Cognitive-behavioral therapy (CBT), a particularly well developed brief treatment that is well summarized in the literature as “efficacious” (Otto and Deveney, 2005), was the primary intervention of choice for EAP cases at thirty-eight percent and General Practice cases at forty-four percent. This may be viewed as a positive finding for the growing number of proponents who advocate for the selection and use of empirically supported interventions. It is also consistent with claims that the CBT movement “has emerged as the dominant force with a growing emphasis on meaning, action, and information in intervention” (Reid, 2002, p. 22). Of course, this finding does not necessarily mean that respondents deliver CBT (or any other short-term intervention) as intended or within the confines of manualized brief treatments more common in controlled conditions.

Small percentages of a variety of models consolidated as “some other theory” came in second for General Practice Counseling at twenty-five percent. These other theories included systems/family systems, behavioral, psychodynamic, motivational enhancement, reality, and humanistic. There are still numerous “single-school” models in use in General Practice settings. “Some other theory” came in third for EAP cases at fourteen percent.

Solution-focused brief therapy was the second theory of choice among EAP cases at twenty-nine percent, compared to six percent of General Practice cases, indicating a shift among a segment of respondents towards using solution-focused in the context of short-term EAP counseling (See Figure 2). For this significant segment of respondents, the type of client (e.g. EAP) affects the choice of interventions ( $df = 16, p = .000$ ). For those clients where a limited number of sessions are available for “free” in the context of EAP, and there is some reasonable expectation the EAP can be helpful without a referral, over twenty percent of respondents appear to shift their intervention approach to solution-focused to accommodate the EAP model. This may be related to the very brief nature of solution-focused and the limits of six sessions within the EAP. This finding supports Gingerich and Eisengart's (2000) contention that solution-focused

therapy is popular because it is very short-term, inexpensive, anecdotally successful, and relatively easy to implement. What appears to be new information is that solution-focused is more prevalent in the EAP service delivery setting than the general mental health practice setting. Gingerich and Eisengart (2000) also conclude that solution-focused therapy does not yet meet the American Psychological Association's standards for determining which treatments are empirically supported, and that more conclusive evidence on the efficacy of solution-focused is needed to fully support its widespread adoption.

Seventeen percent of respondents in the General Practice area and thirteen percent in the EAP area self-identified "eclectic/integrative" as their theoretical orientation. This group looks beyond a single-school approach and attempts to integrate models and techniques to attain change among clients. The emphasis is on being practical in effecting change and rejecting an "either-or" approach. It is not known when or if these various combinations of theories and techniques are compatible and how respondents select or integrate among a large variety of techniques.

It is worth noting that eight percent of General Practice respondents and six percent of EAP respondents utilize "no particular theory or model". Do these respondents equate the simple act of talking to people in distress as a kind of generic intervention? Can the field afford clinicians who utilize interventions with no clear theoretical base or replicable procedures? This segment of respondents likely has a focus on exploratory conversation as opposed to goal-focused symptom reduction guided by a theory.

### **Average Number of Sessions**

When asked about the average number of sessions per "EAP Only" cases versus "General Practice" cases over a one-year period, respondents estimated a mean of 4.22 sessions per EAP case (SD=2.1) and a mean of 11.05 sessions per General Practice case (SD=6.6) (See Figure 3). The mean of eleven cases in General Practice is high when compared to Speer's claim that 50% of clients seeking service in mental health clinics obtain four or fewer sessions and 25% do not return after the first session (Speer, 1998). One obvious difference between short-term

counseling in EAP and General Practice is the average number of sessions is significantly less in the EAP setting. This finding may also help explain the shift towards the use of solution-focused in the context of EAP counseling since it fits well with very limited sessions.

The notable difference in length of stay between EAP cases and General Practice cases raises additional questions: What percent of cases are referred beyond the EAP? How many prematurely discontinue EAP services without meeting their goals? What percent that discontinue discuss with their EAP counselor that they are no longer seeking services? How many clients use “EAP only” sessions to avoid receiving a DSM diagnosis and accessing their employee benefit package with co-payments and deductibles? When is attempting “EAP only” short-term counseling a form of under-treatment?

### **Problem Resolution within the EAP**

A marketing claim that primary EAP vendors routinely make to purchasers is that problems can frequently be resolved within the EAP, thereby preventing utilization of the employer’s self-insured benefit plan, which tends to increase the number of medical claims and expenses. Respondents were asked about the approximate percent of cases where the assessed problem was resolved using short-term counseling within the EAP. Forty-one percent indicated that “EAP only short-term counseling” improved or resolved the assessed problem greater than 50% of the time”. Thirty-two percent stated that EAP only short-term counseling improved or resolved the assessed problem between 26% and 50% of the time. A majority of respondents indicate that short-term EAP counseling is working (See Figure 4).

When asked how they determine if EAP only cases are improved or resolved using short-term counseling, fifty-seven percent stated “clinical impressions and judgment” and twenty-nine percent endorsed “review of the action or treatment plan” (See Figure 5). So, eighty-six of respondents rely on either subjective clinical impressions or treatment plan documentation as the primary standard by which outcomes are determined. Progress notes, or the content of the sessions, are likely the most prevalent form of validation regarding the assessment of outcomes. In the sense that an action plan is a type of contract between the practitioner and client, and a

positive relationship exists between action plan compliance and success, then determination of resolution is based on the practitioner's interpretation of the client's compliance with the plan. Although this form of measurement is very imprecise and practitioner observations are not reliable outcome indicators, it's the most common form of measuring progress.

Only one percent of respondents endorsed using a "formal outcome measurement tool" to determine client improvement or resolution. Client response to intervention can be systematically gathered using several different short questionnaires that are feasible, reliable, and valid. Despite the availability of these tools, very few respondents can produce an outcome measure without manually reviewing their chart or making a subjective clinical determination. The reasons behind the lack of using a more systematic outcome measurement system are unknown and may be related to fear of the results, few resources or automated data collection capabilities, little or no demand from employers, or no formal training that emphasizes the integration of research and practice.

This finding is significant since purchasers want to know why investing in an EAP is more valuable than not investing, or simply offering an outpatient mental health benefit with no EAP. Employers, as primary stakeholders, are placing a greater emphasis on outcomes and results as opposed to just looking at administrative efficiency or price as the main criteria for vendor selection. The predominant practice of simply recording in a progress note that a client is improving or not provides little information on the impact of either EAP or General Practice counseling on workplace variables of interest to an employer.

### **Overlap Between EAP and General Practice Counseling**

When asked if EAP clients are treated the same or differently from other (non-EAP) clients, twenty-eight percent said "completely the same" and forty-six percent stated "more or less the same" (See Figure 6). A combined seventy-four percent indicated that EAP clients are, for the most part, treated pretty much the same as non-EAP clients. Twenty-five percent endorsed "moderately differently" and the remaining two percent "very differently". When there is uncertainty regarding the components that are supposed to make EAP counseling different, then

practitioners will likely rely on the same approach, regardless of the means by which clients come into services. This is a logical stance given that General Practice counselors or therapists may deal with a dozen or more different EAP or managed care vendors, insurance plans, and other diverse referral sources. The impact of EAP concepts on Affiliate behavior can become quite diluted when that Affiliate sees five, six, or more clients a day from differing payment plans and contractual arrangements. Despite the marketing claims of some primary vendors that EAP Affiliates make up a type of tiered or sub-specialty network within their larger managed behavioral health network, this study indicates there is not much contrast between EAP work and General Practice counseling or psychotherapy. This is not the case across the entire field as twenty-seven percent reported that EAP cases are treated moderately to very differently.

An open-ended question posed to respondents asked them to describe how their approach to EAP counseling was similar to or distinguished from their approach to General Practice counseling. Out of 222 total respondents, 183 provided narrative answers to this open-ended question, a response rate of 82% among those respondents who endorsed this open-ended question.

The overwhelming theme in nearly all of the narrative responses centered on the “number of available sessions in EAP” or the “time-sensitive” nature of EAP short-term counseling. The narrative revealed a struggle among respondents to try and accommodate treatment within the parameters of the client’s benefit package (e.g. EAP and outpatient mental health benefits). It seemed as if respondents were trying to cobble together various funding options and make the most out of the number of sessions imposed by the EAP model. As such, respondents seem to develop treatment plans that have potential to fall in line with various payment sources.

Some respondents indicated that EAP paperwork was easier than billing third party payers or managed care for insurance reimbursement. These payers require use of the DSM coding axes and a formal diagnosis, so respondents are pressed to use a diagnosis that yields the greatest likelihood for reimbursement. Since reimbursement for EAP is not tied to having an approved diagnosis (or meeting “medical necessity” criteria), and co-payments or deductibles no

not apply, many respondents see EAP as “less administrative hassle” than compared to the regulations involved with insured clients in the General Practice setting. One of the perceived differences, and benefits, in EAP versus General Practice is that all presenting problems are covered, and particularly those DSM “V” Codes not usually covered under an insurance plan, such as marital conflict, parent-child relational issues, career concerns, stress of work/life balance, and academic problems. Interventions directed towards a couple or family, where symptoms are viewed as manifestations of a faulty system rather than the psychopathology of just one family member, also fit well with the flexibility of the EAP model. EAP fits with Marriage and Family therapists or counselors who are frequently opposed to assigning DSM diagnoses, with the exception of “V” Codes, because doing so “labels” clients and misrepresents transactional processes occurring with the family system (Brown and Bradley, 2002).

Representative quotes from the open-ended question include:

- “Little difference except EAP has fewer visits”.
- “Only difference is some EAPs require switching therapists for additional sessions”.
- “EAP can only be used for here and now issues if the client does not want to access his or her insurance benefits”.
- “EAP focus must be on the most pressing problem due to short number of visits”.
- “I feel rushed with EAP clients when the vendor won’t allow more visits”.
- “I approach all clients the same except EAPs make me cram in the work in a few visits”.
- “I have to be solution-focused if the client won’t stay with me beyond the free EAP visits”.
- “EAP paperwork is less and I don’t have to collect a co-pay since EAP is free to the client”.

There were only a few references contained in the 183 comments related to the EAP approach being different due to a focus on work performance issues and assessing the impact of the client’s personal problems on occupational life or job functioning. Respondents view EAP as largely but not entirely similar to General Practice counseling, and most of the differences reflect

the nuances of coverage, reimbursement, benefit design (e.g. the number of allowed sessions), and an awareness that EAP is at some level about personal problems that overlap with job performance issues.

Despite the theoretical underpinnings of EAP as a workplace performance management program, EAP is only marginally differentiated from standard outpatient employee health benefits in the minds of respondents or Affiliates. It is primarily viewed as a quasi outpatient mental health benefit, or a type of open “employee counseling service” that offers accessible but very brief intervention. Although speculative, if respondents could offer their recommendations to purchasers regarding EAP, it would likely be to allow more sessions within the EAP model. The National Business Group of Health’s (2005) concern that contemporary EAPs have significant overlap with services provided through the employer’s behavioral health benefit has merit, although some degree of workplace emphasis, however diluted, is still present in the EAP Affiliate Network model.

### *Implications*

Given the similarity between EAP and General Practice, some employers are likely paying multiple premiums for an identical or similar service. This finding could potentially cause some employers to re-structure or even eliminate EAPs provided through external vendors and their affiliate networks. This re-structuring or elimination is only advisable if the current EAP model does not support organizational management in addressing workplace problems in a manner that is different from standard mental health benefits. Determining this difference requires a plan to measure EAP specific outcomes.

What is not entirely clear from the employer’s perspective is if the muddying of EAP with General Practice represents an unwanted drift away from a “pure” EAP model. The crucial question is does the contemporary EAP (and its use of the Affiliate Network Model) actually improve the work performance of employees impaired by personal problems any more than providing reasonable access to good behavioral health care? The field needs a study that legitimately compares the outcomes among employees whose behavioral health impairs their

work functioning among employer groups that have “EAP plus benefits” versus “no EAP with benefits”. What are the linkages, if any, between the unique components of EAP and actual outcomes? For example, it is common knowledge that untreated depression has an impact on productivity losses. Would productivity more likely improve for the depressed worker as a consequence of EAP intervention versus seeking help through a behavioral health plan benefit alone? The results of this survey implicate contemporary EAPs as being largely, but not entirely, redundant to behavioral health benefit coverage. Conducting a rigorous outcome study such would shed light on any other actual differences, and test the value of EAP short-term counseling versus counseling in the context of General Practice.

### *References*

Brown, K. and Bradley, L. (2002). Reducing the stigma of mental illness. *Journal of Mental Health Counseling*, 24, 81-87.

Collins, K. (2004). Calculating the value of EAP: Math or myth. *Health and Productivity Management*, 24-26.

de Shazer, S. (1988). *Clues: investigating solutions in brief therapy*. New York, New York: W.W. Norton & Company, Inc.

Employee Assistance Professionals Association. (2003). EAPA standards and professional guidelines. *EAPA*. Arlington, VA. Available from the World Wide Web at [www.eap-association.org](http://www.eap-association.org).

Ensuring Solutions to Alcohol Problems. (2006). EAPs: Workplace opportunities for intervening in alcohol problems. *Primer 5*. George Washington University Medical Center. Available from the World Wide Web at [www.ensuringsolutions.org](http://www.ensuringsolutions.org)

Gingerich, W. and Eisengart S. (2000). Solution-focused brief therapy: A review of the outcome research. *Family Process*, Vol. 39, No. 4, 477-497.

Hartwell, T., Steele, P., French, M., Potter, F., Rodman, N., & Zarkin, G. (1996). Aiding troubled employees: The prevalence, cost, and characteristics of employee assistance programs in the United States. *American Journal of Public Health*, 86 (6), 804-808.

Kurzman, P. (1993). Employee Assistance Programs: Toward a comprehensive service model. In P. Kurzman and S. Akabas (Eds.), *Work and well-being: The occupational social work advantage*. Washington, DC: NASW.

Masi, D. (2004). EAPs in the year 2002. *Mental Health, United States*. Manderscheid, R. and Henderson, M. (eds.) DHHS Pub No. SMA 3938. Substance Abuse Mental Health Services Administration, 209-223, Rockville, MD.

National Business Group on Health (2005). An employer's guide to behavioral health services: A roadmap and recommendations for evaluating, designing, and implementing behavioral health

services. *Center for Mental Health Services, Department of Health and Human Services.* Rockville, MD.

Oss, M. (2004) Current managed behavioral health and employee assistance market enrollment growth masked by program margin pressure. *Open Minds Newsletter*, May

Sciegaj, M., Garnick, D., Horgon, C., Merrick, E., Goldin, D., Urato, M., Hodgkin, D. (2001). Employee assistance programs among Fortune 500 firms. *Employee Assistance Quarterly*. 16 (3), 25-34.

Sharar, D. and White, W. (2001). EAP competence and value. *EAPA Exchange*, November-December, 14-15.

Speer, D. (1998). *Mental Health Outcome Evaluation*. San Diego, CA: Academic Press.

Stout, C., Levant, R., Reed, G., and Murphy, M. (2001). Contracts: A primer for psychologists. *Professional Psychology: Research & Practice*, Vol. 32(1), 88-91.

Figure 1

**Licensed or certified disciplines (N = 222)**  
 (81% masters level and 19% doctorate level)

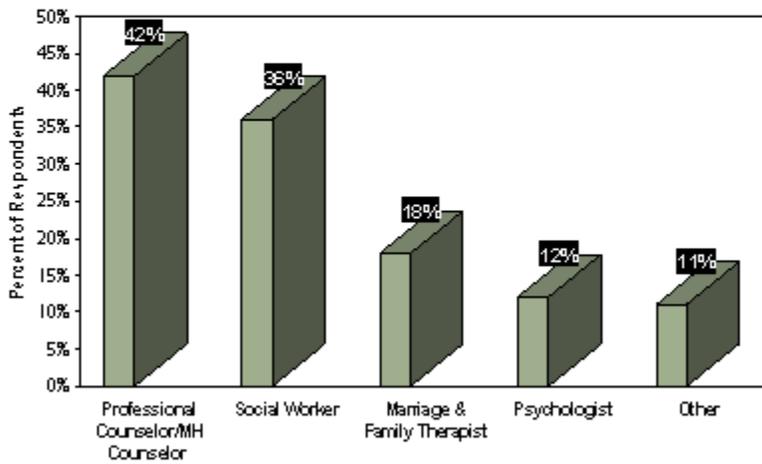


Figure 2

**% Primary theory or model**

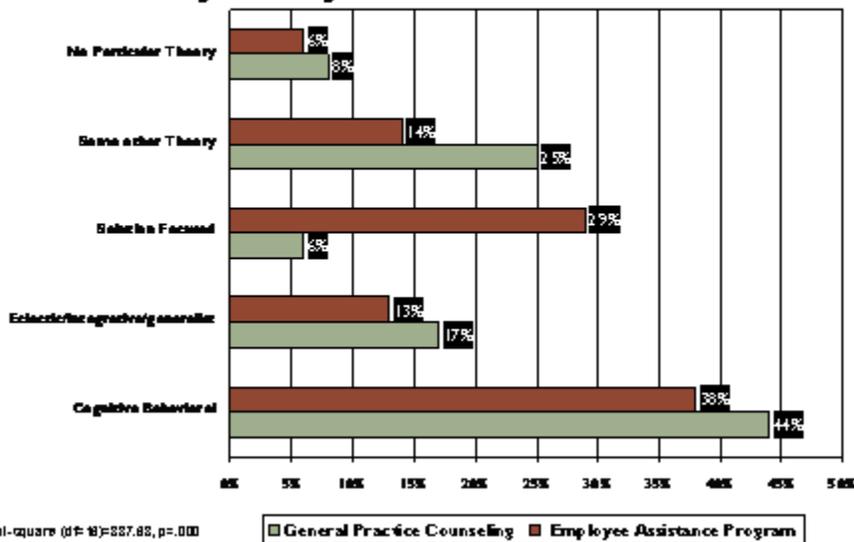


Figure 3

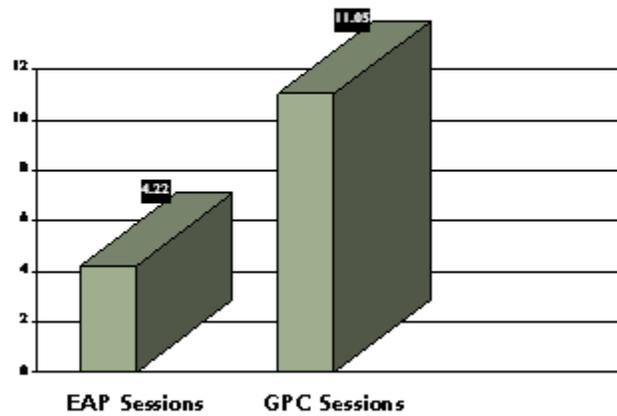
**Average number of sessions per case**

Figure 4

Approximate % of EAP cases where assessed problem was improved or resolved within the EAP:

< 25%	27%
26% - 50%	32%
Greater than 50%	41%

Figure 5

How is improved/resolved determined for cases that only receive short-term EAP?

No way of assessing improvement with in the EAP	1%
Clinical impressions and judgment	57%
Review of the EAP action plan	29%
Formal outcome measurement tool	1%
Other	12%

Figure 6

In terms of therapeutic approach and selection of interventions, are EAP clients generally treated the same as non-EAP clients:

Completely the same	28%
More or less the same	46%
Moderately different	25%
Very differently	2%