EMPLOYEE ASSISTANCE REPORT

supporting EAP professionals

Coaching vs Therapy... pg 7

Volume 19, No. 8
August 2016

19 years of service!

Great Things Come in Small Packages

Highlights of 2016 Wisconsin EAPA Conference

MILWAUKEE, Wis. – It's said that great things come in small packages, and that was definitely the case at the Greater Wisconsin EAPA Chapter's 27th annual Conference on Employee Assistance, held recently at the Best Western Hotel & Conference Center in Milwaukee. There were slightly fewer than 100 attendees, but the keynotes and breakout sessions were every bit as good as many larger conferences in the EA field.

DAY ONE – *Best Practices for the Use of Social Media in Employee Assistance and Mental Health* was the topic of the opening keynote, presented by **Marina London**, web editor with the Employee Assistance Professionals Association (EAPA).

Younger users prefer Instagram to Facebook and Twitter, she said, although LinkedIn is the most important network for professionals. London said that only 9% of teenage social media users have concerns about the privacy of their data – even though "one wrong social media post can ruin your life for good." Even among professionals, "accidental leaks are growing threats," she added. London was referring to how an EAP practitioner not familiar with privacy settings on their computer can inadvertently post a "private" therapist/client conversation for others to see. {She later provided a specific example.) "If you do not know how to use privacy settings, EA professionals should NOT use a platform like Facebook," London stressed.

Blogging Works, but it's not for Everyone

She urged EA professionals to utilize social media because it allows them to showcase their expertise and engage in multiple levels of engagement. As to which channel to use, London said that while blogs involve the most work, they are also the "most powerful."

She recommended checking out the following blogs: www.compeap.com/blogs, http://blog.workhealthlife.com, and on mental health, www.whatsyourgrief.com and www.wheretheclientis.com.

However, blogging is not a good idea for someone who doesn't like writing or who is not willing to make the commitment

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to post entries on a regular basis. Never "dive in blindly," always consider the time and the objective in using any platform first, she stressed. The easiest method, but still useful, is simply to read other people's blogs, follow them, and offer comments.

Videos and Apps

In addition to blogging, YouTube is "another wide open space" for EA professionals to utilize, although she stressed that the user must have great ideas and execution (i.e. a great script) because most videos are poorly done and too long.

Apps are a growing trend. They can be pricey if complex, but quite affordable ($99) for a basic app. London recommended checking out www.appmakr.com.

It's also important to *not* focus on attracting a large number of connections. "A handful of key colleagues are usually more instrumental in getting referrals, speaking engagements, or even a new job, than hundreds of random 'friends,'" she stated.

Best Practices

London's best practices for EAP practitioners included:

❖ **Recognize that it's a challenge being a counselor in a wired world**. Be aware that most people don't think twice about disclosing personal information online.

❖ **Self-disclosure online is almost inevitable**. It is often initiated by clients who want to learn more about their counselors.

❖ **Counselors should develop online technological competence**. Proactively set controls that limit who sees personal information.

❖ **Clinicians should find out whether their professional and personal liability insurance covers social networking sites**. Think twice about the impact of posts, even if privacy settings are used.

❖ **Create and maintain a social networking policy as part of the informed consent process**. A highly recommended resource is the ethical framework compiled by the Online Therapy Institute, http://onlinetherapyinstitute.com/ethical-framework.

Imagining the Clinical and EAP Practices of the Future was also presented by London in an afternoon session. She said that after a recent trip to Las Vegas, it dawned on her that certain things in Vegas had not changed even though she hadn't been there in decades. They included scantily clad women, slot machines, circus shows, and magic acts.

Along similar lines, in spite of today's ever-changing technological innovations, London maintained that certain aspects of society, and EAP, will remain "tech proof." The Urban Dictionary defines tech proof as: "Those objects, activities, feelings or experiences that exist regardless of electronic technology."

According to London: 1) There will still be a need for human contact. 2) There will still be a focus on mental health. 3) There will still be critical incidents and a need for CISM. 4) We will still be assessing and referring. 5) We will still have to educate managers about EA and how to refer underperforming. 6) The very act of helping is *"tech proof*."

"Because everything is moving so fast, we need to set aside time to think about the core values and services of our industry, and work to preserve them," she said in a recent *Tech Trends* column on the same topic. "And then we need to be open minded about implementing the changes in our practices that younger generations will demand and technology will make possible."

Prescription Drug Abuse and the Gateway to Heroin was led by **Karen Wolownik-Albert**, executive director of the Gateway Foundation in Lake Villa, Ill.

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EMPLOYEE ASSISTANCE REPORT

Editor - Mike Jacquart
Publisher - Scott Kolpien
Designer - Laura J. Miller
Circulation - Kim Bartel

Albert said that 1 in 10 Americans and teenagers have a drug and/or alcohol dependence problem, and yet only 11% who needed treatment received it at a specialty facility. Moreover, some doctors feel increased pressure to treat pain, meet patient expectations, and receive high satisfaction scores. In addition, many prescriptions are written and filled in high quantities; 50 pills as opposed to 10 pills.

Warning Signs

Fifty-two million adults have abused prescriptions drugs in their lifetime, and kids think it's safe because they see adults taking them. Red flags for prescription drug abuse include:

- Stealing, forging or selling subscriptions;
- Asking other people for medications;
- Injuries that may be deliberate;
- Excessive mood swings;
- Continually "losing" prescriptions so more prescriptions must be written; and
- Appearing to be high, unusually energetic or revved up, or sedated.

Does Prescription Drug Abuse Lead to Heroin?

❖ This is difficult to prove, but many studies show correlations between prescription drug abuse and heroin abuse.

❖ Heroin acts in the body similarly to opiate pills, but when injected can produce even greater euphoric effects.

❖ Four out of five heroin users started out on prescription drugs.

❖ Changes in prescriptions is an underlying reason behind the heroin epidemic. In 2010, manufacturers of OxyContin developed a plastic-cased pill that made it more difficult to abuse the medication. Within two years, prescription opioid overdoses declined and prescriptions went down. *During this same period, heroin use nearly doubled.*

❖ Cost is yet another factor. The average cost of prescription pain pills is $20-$60, while the average cost of a bag of heroin is only $3-$10.

Recommendations include…

❖ The coordination of care is important. Collaboration includes, but is not limited to specialty doctors, pharmacists, and insurance companies, is critical for success with prescription drug abusers.

❖ Treat the underlying co-occurring disorder, trauma, physical, and emotional pain that drives addictive behavior.

❖ Medication-assisted treatment can help opioid abusers such as Vivitrol, Suboxone, and Bunavail.

❖ Help the client develop coping skills and behavioral strategies to deal with symptoms of pain, depression, anxiety, and sleep problems, without relying on medication alone.

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Editor's Notebook

I have been most fortunate to attend EAPA's World EAP Conference in recent years. It's been a great way to learn more about important topics affecting EAPs, and to meet people from around the world – EA professionals in other countries who are just as dedicated to the field as those in the U.S.

But I had not been to a chapter conference in *years*, so I had little idea what to expect in Milwaukee. I must confess a main reason in going to the 27th annual Conference on Employee Assistance was a rare opportunity to visit with EAPA web editor **Marina London**, other than at the hectic world event where free time is really at a premium compared to a smaller venue. (Marina was a keynote speaker.)

I was *very impressed* with the job put on by the Greater Wisconsin EAPA Chapter. Event organizers **Chuck Austin**, WE Energies; **Kelly Nies**, ThedaCare at Work; and **Lori Wessel**, Holy Family Memorial EAP; were friendly, generous with their time, and did a great job lining up some impressive speakers and presenters. Empathia CEO **Phil Chard**, in particular, was every bit as engaging and informative as any keynote speaker I have heard at the world conferences, and I was happy to tell him as much.

I hope this month's cover story and *Brown Bagger* demonstrate the extremely useful information that was presented. It was a great time.

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Primary Care doesn't help Depression: Study

Although primary care doctors frequently see patients with depression, they typically do less to help those patients manage it than they do for patients with other chronic conditions such as diabetes, asthma or congestive heart failure, a recent study found.

This is important news because research has found that it can be good for patients' health when physician practices have procedures in place to identify and provide targeted services to patients with chronic conditions, and to encourage them to actively manage their own care.

A study that appeared in the journal *Health Affairs* analyzed data from the three largest national surveys of physician practices to determine the extent to which they employed five care-management processes between 2006 and 2013. The five processes studied were patient education; patient reminders about preventive care; nurse care managers to coordinate care; feedback on care quality to providers; and disease registries that identify patients with chronic conditions, enabling practices to be proactive about their care.

The results were particularly dismal for depression. In the 2012 to 2013 time frame, physician groups on average used less than one (0.8) of the care-management processes for their patients with depression, and that level of use hadn't changed since the 2006 to 2007 period, according to the study.

In contrast, practices used 1.7 diabetes care-management processes on average overall with their patients between 2012 and 2013. Among only large practices, the use of diabetes care-management processes grew significantly over time, to 3.2 in 2012-2013.

The depression results were not surprising, said Dr. Tara Bishop, lead author of the study. "There's a growing understanding that depression and mental illness generally are being undermanaged [in primary care settings] and we're not using the tools that are available," she said. ■

Additional source: Kaiser Health News, a national health policy news service that is part of the nonpartisan Henry J. Kaiser Family Foundation.

Resources

Bud to Boss workshop. As a business leader, you must be compassionate AND you must hold people accountable. How can you do that? Check out http://www.budtoboss.com/management/balancing-compassion-accountability.

Parity of Mental Health and Substance Use Benefits with Other Benefits is a free resource from the Substance Abuse and Mental Health Services Administration (SAMHSA) that examines the impact of the Mental Health Parity and Addiction Equity Act. Go to http://store.samhsa.gov/product/Parity-of-Mental-Health-and-Substance-Use-Benefits-with-Other-Benefits-/SMA16-4937.

The Entrepreneurial Culture: 23 Ways to Engage and Empower Your People*, by Michael Houlihan and Bonnie Harvey,* spotlights seven ways to tell if job candidates have the entrepreneurial DNA you want. Visit http://thebarefootspirit.com/. ■

Near-site Health Centers: Coming near you?

Employers have found it difficult to provide cost-effective and high-quality primary care to employees and their family members in recent years, as doctor availability has decreased and appointment wait time has increased in many locales. One solution is to sponsor on-site health centers offering a broad range of services, but that leaves out many employers that lack sufficient concentration of employees or members in any one geographic area.

To fill this gap, employer interest is growing in the concept of a shared near-site in which multiple co-located employers could participate. While the idea has been around for many years, only scattered attempts — with limited results — have brought such efforts to life. It's no simple feat for multiple organizations to synchronize priorities and resources to meet the capital and operating expenses required to operate a near-site health center.

In fact, in most previous cases, a single employer has planned and funded the clinic, and subsequently offered access and services to employees of neighboring companies.

Recently the convergence of many factors make near-site facilities more likely to succeed. They include:

❖ More challenging patient access within the existing medical community, including lengthy waits for appointments or substantial travel or wait time for clinical services in numerous markets.

❖ High cost of care in the local delivery system — usually due to escalating prices often associated with provider consolidation and deleveraged managed care payers.

❖ Increasing employer motivation to offer onsite/near-site services as an employee perk or retention tool.

Willis Towers Watson and Crossover Health recently developed a shared model that has led to positive results. For more information view https://www.towerswatson.com/en/Insights/IC-Types/Ad-hoc-Point-of-View/Perspectives/2016/near-site-health-centers-the-next-frontier. ■

Clinical Perspective

Implant Considered as Treatment for Opioid Addiction

Amid a raging opioid epidemic, many doctors and families in the U.S. have been pleading for better treatment alternatives. One option now under consideration by the Food and Drug Administration is a system of implanted rods that offer controlled release of buprenorphine – a drug already used in other forms to treat opioid addiction. Because it's implanted in the skin, this version of the drug can't easily be sold on the illegal market, proponents say – a key treatment advantage.

The implant system includes four rods, each about the size of a match stick, explains Dave, a paramedic in a small town outside of Boston; he was one of the patients recruited to test the device last year. Dave's worried about reprisal if coworkers find out he is addicted to opioid pain pills, so NPR agreed to use only his first name.

"My implants were placed in my left arm, just above my elbow on the inside," he explains. He's been in recovery for four years — previously with the help of daily buprenorphine pills. Last year, he agreed to be part of an experiment that delivered regular doses of the drug to him via an implant instead. He's sold on the new approach.

"I felt completely normal all the time," he says.

Probuphine implants, inserted under the skin by a trained doctor, are left in place for six months at a time. Dave says the rods are convenient, safe and discreet — they provided steady relief from his cravings. ■

Additional source: NPR.

Supporting Our Veterans

New Course on Sleep Offered

Sleep disturbance is common among those with post-traumatic stress disorder (PTSD) and may lead to exacerbation of PTSD and other comorbid symptoms. The Veterans Administration's National Center for PTSD has created a new online course for providers on the "Assessment and Treatment of Sleep Problems in PTSD."

This free course provides information on PTSD and sleep problems, the advantages and disadvantages of pharmacological and cognitive behavioral interventions, and different ways these interventions can be implemented.

The course also includes videos that demonstrate assessment of sleep-related problems and the tools included in Cognitive Behavioral Therapy for Insomnia.

The 5-hour course offers free continuing education credit. It can be found, along with a number of other online courses, at: http://www.ptsd.va.gov/professional/continuing_ed/assessment_tx_sleep_problems.asp. ■

In the News

EAPA Endorses WOS as EAP Best Practice

The Employee Assistance Professionals Association (EAPA) recently announced is official support and endorsement of the Workplace Outcome Suite (WOS) as an EAP best practice for measuring and evaluating work-related outcomes of EA services.

The WOS is a free, psychometrically valid and reliable, and easy to administer tool developed by the Chestnut Global Partners (CGP) Division of Commercial Science.

Under the terms of an agreement between EAPA and CGP, an annual industry-wide aggregate report, including pre and post WOS data across EAP settings, will be available as a member benefit exclusive to EAPA members. For more information visit http://www.eapassn.org/WOS or contact Dave Sharar, dsharar@chestnut.org.

Editor Mike Jacquart contributed to this report, titled: "EAPs Can and DO Achieve Positive Workplace Outcomes." ■

Supporting Our Veterans

How Veterans-friendly is YOUR EAP?

An EAP can be an invaluable tool when addressing the needs of veterans in the workplace. Counseling can help manage mental health conditions or substance abuse, and an EA counselor can connect veterans to other resources that are available locally.

How veterans-friendly is YOUR employee assistance program? According to the U.S. Department of Veteran Affairs' *Veterans in the Workplace* study, a veterans-friendly EAP will exhibit the following characteristics:

❖ An intake, assessment and referral process in which confidentiality is emphasized.

❖ EA counselors trained in knowledge of military culture and who know how and when to assess for PTSD, risk of suicide, substance abuse, depression and anxiety.

❖ Counselors who recognize when to refer to another provider or connect the veteran with treatment resources.

❖ The ability to provide education on VA resources for veterans and their families.

❖ Management and supervisor consultation regarding military transition issues, appropriate responses to employees who exhibit behavioral issues, and how to encourage and de-stigmatize the use of EAP services by veteran employees.

❖ Training programs for employees, supervisors, managers and EAP providers. ■

Additional source: Sally Hartman, EAP counselor with FEI Behavioral Health.

What is the Difference between a Coach and a Therapist?

By DeeAnna Merz Nagel

When I became a coach several years ago, one of the most difficult tasks for me was truly understanding the difference between coaching and counseling. They are distinct orientations, yet many say they are not. After all, when I took coaching courses for my own coach certification, I didn't "learn" anything new. I had learned many of the theories and techniques in graduate school.

My "ah-ha" moment came when I realized that I was pretending to practice coaching while maintaining my psychotherapy practice, relying on the influence of my counseling license for client referrals and continuing to network and be influenced by the counseling profession.

To solve the dilemma I became a coach. Full on. My professional identity morphed from psychotherapist utilizing coaching techniques, to psychotherapist and coach, and finally, WELLNESS COACH. I am a wellness coach who has integrated alternative approaches such as energy healing, essential oils and intuitive readings into my practice. And all with a divine shift in language and purpose! I would have never found ease in integrating these other approaches into my psychotherapy practice.

Clarifying the Distinction

I worked with trauma survivors for years — my post-graduate supervision focused on adult survivors of sexual abuse. Now that I am coaching I see that I always used tools that were not exclusive to counselors but used by coaches as well. In fact, many tools I used as a counselor were rooted in positive psychology.

The difference, particularly for a licensed practitioner, is that we must absolutely separate our coaching endeavors from our counseling endeavors. We may on occasion, pull tools from the toolbox that a coach may use, but that is simply a technique – an intervention – while the primary contract with the client remains counseling. This means that a trauma client still working through the throes of trauma and historical events would *not* be a candidate for coaching services even from a licensed mental health practitioner.

If you are working with a client under a coaching contract, and you discover the core issues of trauma are present and remain unresolved, you are ethically obligated to refer that client. So be sure you have thoroughly assessed the client for the proper services before assigning the client to either coaching or counseling. Another way to look at it is, if you are coaching you are not referring to disease, diagnosis, or any other words or use of medical model language.

Making a Decision

Ultimately, I had to choose. And I chose to be a coach. Some people can wear both hats and keep distinctions between the two roles. They keep the two practices separate, with separate informed consents, even separate websites.

But for me, I was no longer fed by my role as a psychotherapist. The field is entrenched in finding and fixing pathology and even if I flipped my own paradigm, I was constantly surrounded by rhetoric, continuing education and rules that did not serve me as a professional any longer. That was hard to face. I invested a lot in my schooling and professional identity and while I choose not to work directly within the profession any longer, I wouldn't change my path. It is part of my life quilt. ■

DeeAnna Merz Nagel remains involved in the Online Therapy Institute (http://onlinetherapyinstitute.com) although her main efforts now focus on wellness coaching. For more information, visit www.havanawellnessstudio.com or http://www.havanawellnessstudio.com/intuitive-wellness-coach-certificate/.
***Editor's note**: A longer version of this article previously appeared in the December 2015 issue of "EAR" and is being reprinted due to interest in this subject matter.*

Recognition That Misses the Mark

A little recognition at work can go a long way, a survey from OfficeTeam finds. Nearly half (49%) of professionals interviewed said they would be somewhat or very likely to leave their current position if they didn't feel appreciated by their manager.

"Professionals want to know their contributions make a difference and will be rewarded, especially Millennials," said Robert Hosking, executive director of OfficeTeam. "Because individuals like to be acknowledged in different ways, managers should find out what their workers value most and customize recognition accordingly."

Although people enjoy different types of appreciation, some tokens of gratitude universally miss the mark. Following are five of the most common recognition mistakes:

❖ **Not getting facts straight.** Nothing's more embarrassing than incorrectly acknowledging a person's name or individual accomplishment.

❖ **Offering token gestures.** The form of recognition should fit the degree of achievement. Giving someone a stapler for his or her five-year anniversary, for example, sends the message the milestone is insignificant.

❖ **Being vague.** Telling employees they did a "good job" is a generic form of kudos. Tie acknowledgment back to specific actions so people know exactly what they did right.

❖ **Going overboard.** Recognition doesn't need to be extravagant to be effective. Small everyday things, such as saying "thank you," an inexpensive gift card or giving credit for good ideas can be powerful motivators.

❖ **Overlooking contributors**. Although some workers naturally gravitate toward the limelight, don't forget to also celebrate unsung heroes who help behind the scenes. ■

Source: OfficeTeam (www.officeteam.com).

Great Things... cont'd from Page 3

Realistic Optimism – What is it? How can it help?

DAY TWO – *Realistic Optimism: Meeting the Challenges of Change in Trying Times*, was presented by keynote speaker **Philip Chard**, president and CEO of Empathia, Inc. "Realistic Optimism" is a learnable attribute that is pivotal in successfully meeting the many challenges of personal change, including those brought about by the rapidly shifting landscape of healthcare. Unlike "pie in the sky" optimism, research shows that the realistic variety allows us to adapt, become resilient, and even excel in the face of rapidly shifting demands and persistent stressors.

Realistic optimists know how to balance optimism with realism, according to Chard. "It is a middle ground between 'pie in the sky' thinking and pessimism," he said. Realistic optimists are also flexible and recognize opportunities, but they do not "promise" X, Y, or Z in the workplace.

Realistic optimists also become good at rephrasing negative self-talk into good self-talk. This involves going from thinking... "It's hopeless," to… *"What can be done?"* … "It's all or nothing," … to… *"There is a middle ground."* … "The sky is falling!" … to … *"The last I looked, it's still up there."* …. "I'm a victim" to… *"I'm an agent."*

Chard said realistic optimists also engage in "power poses" throughout the day such as deep breathing, nature walks, listening to music, and "micro exercise." Rather than having your mind full of too many things, the idea is to be "mind-FUL" of the here and now, and learn how to "live in the moment." (**Editor's note**: The impact that mindfulness is having on reducing stress in the workplace is discussed in this month's *Brown Bagger* insert.)

Realistic optimism also involves changing other timeworn concepts that really aren't true such as… not managing time, but managing *energy*; not avoiding stress, but *engaging* stress (i.e. successfully addressing it), and from thinking that downtime is wasted, to recognizing that downtime is actually *productive*.

"Realistic optimism is about *attitude* and *energy*," Chard said. "How you *feel* and *behave* leads to which fork in the road you take." ■