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EVALUATION OF THE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

EMPLOYEE COUNSELING SERVICES PROGRAMS

EXECUTIVE SUMMARY

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EVALUATION OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES EMPLOYEE COUNSELING SERVICES PROGRAMS

EXECUTIVE SUMMARY

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An evaluation lasting over thirty months and needing to surmount a number of technical difficulties and some non-technical barriers could not succeed except for the dedicated effort of many people. I wish to acknowledge the help of all these people, not all of whom I can name individually in this limited space.

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EXECUTIVE SUMMARY

It has been estimated that deteriorated job performance on the part of troubled employees with alcohol, drug, emotional and other problems represents a major cost to both public (Comptroller General of the United States, 1970; Gould, 1981; the Reporter, 1981) and private (Filipowicz, 1979; Goldbeck and Kiefhaber, 1981, Sorenson, 1978) organizations. Employee Assistance Programs (EAPs) have been instituted in both public agencies and private industry to help troubled employees overcome problems that have led to deteriorated job performance. The U.S. Department of Health and Human Services (HHS) has established such a program called the Employee Counseling Services (ECS). At an annual investment of 1.2 to 2.0 million dollars, the ECS program is intended to increase troubled employee productivity and thereby significantly reduce the $148,500,000 estimated annual cost of lost productivity (Masi and Teems, 1983; Masi, 1984). With about 2,000 employees receiving ECS services per year, each with an average annual salary around $21,000, only a mean 5% improvement for one year (yielding $2.1 million saved) would justify program costs on a cost-benefit basis. However, if the annual net benefit were higher than 5% and/or the net benefit could reasonably be expected to continue longer than one year after ECS intervention, then the return (benefit) per dollar or staff-person investment (cost) could potentially entail a quite favorable cost-benefit ratio. The extent to which the ECS program is improving productivity of troubled employees relative to its cost of operation was a significant part of this major evaluation study conducted by Development Associates, Inc. for HHS. However, the study also obtained other important results from intake and client impact data as well, with implications for ECS program management and potentially for the EAP and occupational health fields more generally.

The major points from each of the four chapters of the full Summary Evaluation Report are summarized in the next four sections of this Executive Summary.

I. Introduction (Chapter I)

The ECS program had its roots in EAPs that sprang up in the 1940s and 1950s in several large U.S. companies. Public sector involvement in such programs was given impetus by Public Law 91-616 which was promulgated in 1970 and Public Law 92-255 in 1972. Lead responsibility for developing EAPs in federal agencies was given to the Office of Personnel Management (OPM) and the Secretary of HHS.

Through much of the 1970s, EAPs were established on an ad hoc basis in HEW (now HHS). In 1979, the Secretary of HEW, Joseph Califano, announced a major initiative to combat alcoholism. Prior to this initiative there was no official implementation at the secretary level of a program satisfying PL 91-616, the "Comprehensive Alcohol Abuse and Alcoholism, Treatment, and Rehabilitation Act of 1970." Mr. Califano's directive provided the impetus for developing fully operational ECSs to cover all of HEW. Furthermore, it established this program with the intention that it serve as a model for other departments and agencies of the federal government, for state and local governments, for business, for labor, and for other organizations.

Mr. Thomas McFee of the Office of the Assistant Secretary for Personnel Administration (ASPER) was assigned responsibility for implementing the model (ECS) program. On October 3, 1980 the ASPER signed an agreement with OPM (OPM, 1980) which delineated the roles of the respective agencies and identified special HHS duties regarding the model program. One such duty was the development of a program review and evaluation system. In fact, Thomas McFee (ASPER) noted that the development of an evaluation system was of highest priority. His view was that unless EAPs could be clearly shown to produce benefits in a cost-effective way, they were likely to be eliminated during times of budget cuts and belt tightening.

The ECS would not exist as a coherent program or at its current strength, despite RIFs in HHS, except through the impetus and support provided by Mr. McFee (ASPER) and the continued support of HHS secretaries since Mr. Califano including the current HHS secretary, Ms. Heckler. The ECS program currently consists of 15 operating units: 10 regional offices and 5 headquarters offices. It is intended to serve both supervisors and their troubled employees. The units utilize a broad-based approach emphasizing intake, assessment and referral to outside treatment. ECS Units generally are limited to the provision of only short-term counseling at most. It is a particular goal of the HHS Employee Counseling Program to encourage referrals to ECS by supervisors as much as possible, rather than relying solely on a more passive self-referral approach.

While the ECS Director in the Office of ASPER, provides overall program coherence through policy implementation and direction, there are substantial differences among the units. Some units have been operational since the early 1970s, while others are still under development. Other units are relatively new, but include old components. For example, the Region 9-San Francisco unit began in the early 1980s, although it includes an EAP located at an SSA Program Service Center (PSC) that has been in existence since the early 1970s. While some units involve a single site, others are comprised of several sites. Regional units serve a geographically dispersed population, while headquarters units serve employees who are more geographically concentrated. The spread of employee populations for the two types of units create very different outreach problems.

Staffing patterns also vary among units. Some units have full-time directors, while others have part-time directors. The amount of director time for a unit varies from full-time to as low as 10 percent time. Total available staff time ranges from one person at 10 percent time to as many as 16.6 FTE staff. The source of staff among units includes in-house HHS staff, on-site contractors or consortia, outside consortia, and/or volunteers or social work students under university supervision.

Having undergone an extensive design and development process in HHS for nearly two years, the emergent evaluation plan as operationally designed over an eight-month period and implemented by Development Associates over an addition seventeen-month period had the following key features:

- Assurance of client confidentiality and compliance with privacy requirements;

- Maximum compatibility with ECS program policies and procedures;
- Minimum necessary burden to ECS units and others;
- Timely feedback to provide information for management decisions;
- Sufficient rigor to assure credibility of results through the collection of individual level data; and
- Acquisition of a full range of evaluation data from intake, to client impact, through outcomes in terms of cost-effectiveness analyses (CEA) and cost-benefit analyses (CBA).

The evaluation system was made up of five components. These were: context, inputs, process, impact and outcomes (CIPIO model). This was a variation of the Stufflebeam CIPP Model of evaluation (Stufflebeam, 1971) which was designed for the ECS evaluation by Development Associates to provide on-going management feedback, while building the data base for an overall summative evaluation.

To obtain data about these five components, a comprehensive management information system was developed. It consisted of ECS Unit Quarterly Reports and the Client Tracking System. The Client Tracking System (CTS) was comprised of three parts. It included Client Status forms, Work Performance Rating by Supervisors forms and leave data from payroll records. Individual client status and work performance data were recorded in coded, nonpersonally identifiable form by the ECS Unit Counselor or Director from clients, their records, supervisors, treatment providers or others as appropriate. Payroll leave data were accessed via computer by the ECS Unit Director.

For each client, these data were collected at three points in time: at intake, three months after intake, and nine months after intake. At any one point in time, an ECS unit was working with a number of clients in various stages of intake and follow-up. Data from the CTS were assembled quarterly and along with the Quarterly Report were forwarded to the evaluators at Development Associates. The recording of data by the CTS began May 1, 1983 and was completed as of September 30, 1984. Data processing, including quality control checks and callbacks to the ECS units, took several more months. Summaries of the analyses of the full data collected are reported herein.

II. Client Process Data at Intake (Chapter II)

Selected cumulative client intake data are presented covering intakes from May 1, 1983 to September 30, 1984 as reported by the Client Tracking System (CTS). The first part of the chapter focuses on overall program data regarding types of ECS client problems and related variables. The second part of the chapter discusses the same variables broken out by ECS unit. The data reflect the intake status of 2,442 clients who came into the CTS during the seventeen-month period covered.

About 54 percent of ECS clients for the time period and units covered fell into mental health or various alcohol and/or drug related categories; the kind of problems ECS is particularly aimed at uncovering. However, that means that 46 percent fall into other categories, some of which may be out of scope for ECS.

The data on referral source indicated that overall 35 percent were supervisor-referred, philosphically a strong focus of the HHS program, while the rest were mostly self-referred. However, the Regional Units obtained, 45 percent of their clients through supervisor-referrals, while the Headquarters Units received only 27 percent of their clients through supervisor-referrals. It would appear that the Headquarters Units as a whole, could do substantially more to develop supervisor-referrals of clients. However, the difference between Headquarters and Regional Units apparently is more attributable to the two Headquarters Units that follow a Medical Model EAP approach, which have only 11 percent of their referrals via supervisors. Mixed-staff Units had the highest level of supervisor-referrals (57 percent), In-house Units were intermediate (38 percent), and Outside-staffed Units were lowest (21 percent).

The ratio of males to females is not far from the overall HHS work force ratio, although perhaps slightly under-representative of males. However, there was some indication that while upper GS level employees were being reached, they were not being reached to the extent expected by their numbers in the Department. Hence, it would appear useful to increase outreach efforts aimed at reaching these employees more. This in turn would likely increase the male ECS clientele, since males are very substantially over-represented in the upper GS levels of HHS compared with their representation at lower GS levels.

While the Regional Offices have only 32 percent of the staffing for the parts of the ECS program covered by the CTS, they have 44 percent of the clients. This is true despite the fact that the Regional Units have far more dispersed employee populations than the Headquarters Units and also despite the fact that several of the ECS Regional Units were not very productive. If the three SSA PSCs not participating in the CTS were also included, the Regional Offices apparently greater client production efficiency would be somewhat greater. However, since the regions contain about two-thirds of the employees, yet yield only 44 percent of program clients overall, despite higher overall efficiency (production of clients per staff person) compared with the Headquarters Units, an increase in staff resources in the regions appears needed. Increasing either staffing or the efficiency of the three or four low production Regional Units should also substantially improve the picture.

On the other side of the coin, it would appear that reduction of some of the non-counseling staff in one or more of the Headquarters Units may be possible without detriment to their production of clients.

There was some evidence that In-House staffing yielded a higher percentage of alcohol or drug problem clients. This may be partly related to differences

in supervisor-referral, which tends to be associated more with alcohol and drug problems than self-referral. So there is some risk that current ECS movement toward greater dependence on outside contractors or consortia may yield still lower proportions of clients with alcohol or drug problems unless countermeasures are taken. The high level of supervisor-referral via Mixed Units suggests continued In-House involvement could help; although this did not manifest itself in higher alcohol or drug related cases for this study.

III. Client Impact Results (Chapter III)

This chapter focuses upon evidence regarding ECS program impact. To fully assess client impact within the CTS evaluation system, it was necessary to obtain both three-month and nine-month follow-up data to compare with client status at intake. Therefore, this chapter covers only the three intake cohorts for which both three-month and nine-month data were available. These were also the cohorts on which, for the most part, the cost-effectiveness (CEA) and cost-benefit (CBA) outcome analyses were calculated and reported in Chapter IV. Typically, between 70 to 95 percent of the potential data were available for analysis through the nine-month follow-up for the 1237 ECS clients in these cohorts.

The following three types of impact measures were the primary focus of this chapter:

- Changes in the client's level of functioning as assessed by the ECS counselors;
- Changes in the client's work performance as assessed by the client's supervisor; and
- Changes in the client's leave usage assessed from HHS payroll records.

Since the ECS is intended to be primarily a program for intake, assessment, and referral to outside treatment providers as appropriate, with no more than very limited short-term counseling by the ECS unit staff, program impact is to a large extent necessarily dependent on ECS clients accepting and following through on recommended treatment. It is also dependent on the efficacy of community treatment programs. Thus, the following observations about client treatment status at nine-month follow-up need to be considered in the interpretation of the impact results, as well as for interpretation of the CEA and CBA results presented in Chapter IV:

- about 23 percent of ECS clients were still in some form of treatment, although in many cases this may only be continuing peer self-help groups or be related to chronic physical health problems;
- only about 31 percent had completed treatment;
- about 19 percent either did not accept the counselor's recommendation or dropped-out of treatment early; and

- about 19 percent did not have a problem for which the counselor considered some form of treatment appropriate, not even ECS short term counseling.

The first of these observations tends to imply that full impact of the program may not have manifested itself fully even at nine-month follow-up, particularly regarding ECS clients with alcohol or drug related, mental health, or physical health problems. The rest of the observations tend to imply that impact effects may be attenuated somewhat over the ideal situation of all ECS clients accepting and completing recommended treatment.

Despite the observations about treatment status at nine months, two of the three kinds of impact measures used for ECS assessment showed favorable effects for the program as a whole. The effects seem strongest for the counselor-based measures, but these are the most subjective and potentially biased of the three kinds of measures. The effects were strong, but somewhat less for the supervisor-based measures. The impact effects were inconclusive for the leave data; while they were the most objective and least subject to bias, they were also most erratic and relatively poor evaluative measures. However, the leave data did clearly show ECS clients used substantially more leave than HHS employees as a whole, showing that the program did serve employees for whom there was a substantial potential payoff to the Department in terms of leave reduction. In summary, intake to 9-month follow-up:

- Client functioning ratings generally went from average ratings of mild to moderate impairment at intake up to only mild impairment or to functioning well;

- supervisor ratings generally went from negative ratings indicative of below average performance relative to other employees supervised up to positive ratings, possibly indicative of above average performance; and

- leave usage for ECS clients may have dropped some relative to the HHS norm groups (high variability and poor measurement properties of the leave data precluded a definitive assessment); but clearly was substantially above the Department norms for all six cohorts before and after ECS intervention, and this was particularly true for supervisor-referred clients.

IV. Cost-Effectivess and Cost-Benefit Analyses

A major issue in evaluation of the ECS program concerns the relationships between the costs of the program and the related outcomes and benefits. There are two types of analyses that can be performed on such data (Schramm 1980, 1982; Yates, 1980): (1) cost-effectiveness analyses (CEA), in which program costs are compared with some quantitative measure of program output, and a cost per unit is calculated (cost per client-found, annual clients per FTE, penetration/per capita dollar, cost per unit change in client status, etc.); and (2) cost-benefit analyses (CBA), in which program costs are