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CHAPTER 24

A METHOD FOR OBTAINING FOLLOWUP OUTCOME DATA

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The effectiveness of a mental health center is best assessed in terms of the outcomes for clients who receive the center's services. A direct and efficient way to assess outcomes is by means of sampled followup contacts using an outcome instrument that is reliable, valid, tailored to the goals of the center, and applicable to all clients served. The Mental Health Systems Evaluation Project at Denver General Hospital has developed an instrument which aims to fulfill these criteria. It is designed as a questionnaire to be completed during a semi-structured interview. This instrument, the *Denver Community Mental Health Questionnaire*, is reproduced and discussed in an earlier chapter of this volume and by Ciarlo and Reihman (1974). The scale was designed for persons between the ages of 18 and 65 and has successfully been administered to a vareity of ethnic and socioeconomic groups. Interviews are carried out in the client's home. This is important because the client seems generally most comfortable in his own environment and seems to be more open and honest with his responses than when interviewed in the clinic. This paper describes the way in which the followup questionnaire is used in evaluating the outcome of services provided by the Denver General Hospital Community Mental Health Center.

Selecting a Sample for Followup

One goal of the Systems Evaluation Project is constantly to monitor representative client outcomes over time. The condition of successive samples of clients is assessed 90 days after their admission to a serving element in the center. An intake form is completed on every client at the time of his or her initial contact with a serving element. The intake form includes pertinent demographic variables and location information (e.g., age, sex, address, phone number) as well as relevant diagnostic information and disposition.

Copies of the intake forms are collected by evaluation staff and are forwarded to the project "code shop." Here they are checked against existing records to verify that the agency numbers are correct and unduplicated. Intake forms are then coded and keytaped by members of the evaluation staff and entered into a computerized master client file.

Each month a sample of clients is selected for followup, stratified by "major problem category" coded at intake. This category represents a combination of the client's major problem(s) and the intake clinician's primary treatment goal. Table 1 lists the major problem categories currently in use. Within each of these categories a random sample of clients is selected for followup. The size of these samples varies with the number of clients treated and the interviewer time available, but with the aim of obtaining 30 completed interviews for each of the first eight problem categories every 3 months. This sample size is large enough to detect modest changes in average client outcome over time. Sampling by problem category rather than treatment unit makes it possible to evaluate the effects of shifts in intake screening and referral patterns within the center, shifts that may result in improved effectiveness.

Each month a computer listing of intakes by major problem category is produced to facilitate sample selection. This printout also lists the other client information useful in completing the followup contact—age, ethnic group, primary diagnosis,

Table 1. Relative Frequency of Nine Major Problem Categories as Rated by Intake Staff for a 1-Month Sample of 772 Applicants to the Northwest Denver Community Mental Health Center

Major Problem Category	*Frequency*	*Percent*
Alcohol Abuse	274	35.5
Drug Abuse	57	7.4
Antisocial Behavior	7	0.9
Somatic Complaints	11	1.4
Disorganized Thinking/Behavior	69	8.9
Emotional Distress	188	24.4
Maladaptive Behavior	99	12.8
Personal-Social Handicap	57	7.4
Information and Referral	10	1.3
Total	772	100.0

agency number and serving element, date of admission, voluntary/involuntary status, referrals made, address and telephone. The clients selected for followup are randomly assigned to the followup interviewers. A client list is prepared for each interviewer which provides the above information, indicates the date on which the client should be seen, and provides space to record the contact attempts made by the interviewer.

Locating the Person To Be Interviewed

At this point each interviewer attempts to locate clients on his/her list. Frequently the phone number and address supplied at intake are inaccurate at followup, 90 days later. If the telephone has been disconnected, the telephone company is queried about a new listing. The hospital central registry is checked for new address information on the client. A letter can also be sent to the client indicating that he will be contacted. If the letter is marked "address correction requested," the post office will supply any forwarding address it has, for the price of a first-class stamp.

Other agencies will sometimes help in locating a client. The client's original referral source is checked for new address information. A number of clients end up in the county jail, and one of the evaluation staff members has received security clearance at the jail and is responsible for all client interviews there. Probation or parole officers may be contacted if the record indicates that the client has some contact with them. The welfare agency has also been willing to help locate clients who are welfare recipients. Interagency help of this type depends on establishing a working relationship in which each agency safeguards the confidentiality of client data obtained from the other.

The followup interviewer checks each known address at least once. If it is determined that the client has moved, neighbors are queried as to possible new addresses. To safeguard client confidentiality, however, information regarding the purpose of searching for the client is released to one other than the client. If the followup worker has reason to assume that a client lives at a given address, he makes a maximum of three home visits at different times of the day and evening, each time leaving a note asking the client to contact him, either at the office or at his home.

Selecting and Training Interviewers

The interviews are carried out by a team of trained followup interviewers. Evidence of skill in dealing with people on a one-to-one basis is the major criterion in recruiting interviewers. Methods for locating clients, methods for obtaining client cooperation, and a review of community resources are stressed during a 2-week training period. Information about the mental health center and the functions of each serving element is reviewed. This is important so that the interviewer can respond appropriately to client questions about the interviewer's relationship to the program.

Role playing is a major technique utilized in teaching the methods of interviewing. This helps the interviewers become familiar with the use of the questionnaire and enables the trainer to help the interviewers find the appropriate blend of rapport and objectivity when interviewing clients. Group ratings of role-played clients help to improve interrater agreement by revealing misunderstandings about the use of the questionnaire items.

Enlisting Cooperation and Performing the Interview

It requires some interviewer skill to quickly establish rapport with a client and gain entry into his home so that an adequate interview can be conducted. Interviewers are supplied with identification cards and are instructed to identify themselves to clients as being members of a research team which evaluates the effectiveness of the community mental health center. He explains that this is done by talking with people who have received services from the center. The interviewer stresses that the client's cooperation is important in improving effectiveness of the center for himself and others who may use the center's services in the future. Most clients readily agree to the 30-minute interview. Attentiveness on the part of the followup interviewer will usually reduce the client's initial reticence. It is essential, of course, for the followup worker to communicate respect for the client as an individual who has a problem. The interviewer assumes a nonjudgmental position but takes an active part in the interview. Nonverbal cues are as important as the stated cues in conducting an interview. Because the interview contains personal questions regarding family and work relationships, the interviewer must not display disapproval or curiosity when asking questions. As the interview proceeds, the worker tries to be honest and forthright, yet aware of the client's sensitivities.

In spite of these efforts to establish rapport, there are clients who are unwilling to cooperate with the followup interviewer. In these instances the followup worker reminds the client that the interview only attempts to evaluate the services of the center and is not designed to single out the client himself for special recognition. It is also reiterated that the

client's help is critical in evaluating and improving the center's effectiveness. If the client had a negative experience at the center and he says, "I hate that place and everyone in it," the followup worker tactfully says, "Well, now that's exactly the kind of information we would like to discuss with you." Most clients who are initially reluctant will consent to being interviewed. Interviewers must be persistent and persuasive while acknowledging the client's wish for privacy and respecting the fact that the client is under no obligation to participate.

Scoring the Interview

Upon return from the interview with the client, the interviewer completes any brief notes taken during the interview and then goes through the interview again, question by question, scoring each item and computing scale scores from combinations of items. At this time, raw scores on each scale are converted into "community standard" scores, with a mean of 50 and a standard deviation of 5 for each of the 12 scales currently in use. By scoring clients in terms of a "normal" group—a randomly selected and interviewed sample of the entire Denver population—it is possible, directly and immediately, to see how a client compares with similar clients, and also to see how closely a group of clients is approaching the community average in each area of social and personal functioning at outcome. This standardization of scores also permits each area of functioning to be directly compared with other areas, so that relatively better or poorer functioning areas are immediately apparent.

Functioning and Cost of the Followup Program

Using these methods, it has been feasible in the Denver center to monitor client outcomes for the first eight major problem categories, although in the less common categories more than 3 months is sometimes required to gather an adequate sample. The rate of successfully completed followup interviews has averaged 56 percent of the sample drawn. Most of the attrition is due to inability to locate the client. A few are not interviewed who have moved out of metroplitan Denver. Only about 2 percent of the total sample directly refuse to be interviewed when contacted in person. The overall rate of 44 percent attrition is greater than has been reported in many funded research followup studies, in which admission contact is also made with each client, more persistent efforts are made to locate subjects, and travel funds are available to contact those who have moved from the area (e.g., Bookbinder 1962; May, Tuma, and Kraude 1965; Paul 1968; Sindberg 1970; Sinnett, Stimpert, and Straight 1965). For purposes of program evaluation in the Denver center, a higher attrition rate has been accepted in exchange for economy of operation.

A full-time interviewer is assigned 60 clients per month, of whom about 30 can be located and seen. The followup staff typically consists of three full-time interviewers and a supervisor. The supervisor does some interviewing but primarily concentrates on training, monitoring data adequacy, and carrying out analyses of the data. About one-quarter of one secretary's time is also utilized, plus a modest amount of computer time for sample construction and data analysis. These resources have been sufficient for close to 1,000 completed interviews per year. The computerized client data system with its "code shop" staff is important to the followup program; however, these data are also needed for other program evaluation tasks, and one should therefore exclude those costs from the "marginal cost" of adding this type of client outcome monitoring to an already developed program evaluation effort.

Utility of Followup Evaluation

What can one hope to gain from this additional investment? Most community mental health centers are not yet investing any significant resources in outcome monitoring (Hargreaves et al. 1975). In the Denver program, both the center management and the evaluation staff are in the process of learning how to utilize client outcome information in order to improve program effectiveness.

Summaries of outcome scores for the first 15 months of the followup work have been provided to program managers, citizen advisory boards, and State-level executive and legislative budget committees. In general, the response of the boards and funding authorities has been positive, in that they recognize that the data indicate reasonably good functioning of followed-up clients in comparison to clients at admission. However, their response has been limited to acknowledgment of satisfactory program performance. It may be that this limited type of response is what one can typically expect from "externally oriented" evaluation, where the results are provided to persons or agencies outside the direct management of the operating programs.

In sharp contrast, the reactions to the "internally-directed" feedback have been more critical and searching and ultimately much more enthusiastic. For example, the inpatient service is planning to use these outcome data to help set standards for how long persons would generally be kept in the

hospital. Similarly, outpatient team leaders plan to compare outcomes for differing lengths of treatment and for group therapy in contrast to individual therapy, attempting to improve the overall effectiveness of outpatient treatment programs within the limits of the program resources. A third example of program managers' reactions is shown by the shift in thinking about job placement and vocational counseling among alcoholism program staff. After the outcome data showed that the "productivity" scores of most alcoholism clients were not substantially different from the community average, either at admission or at followup, program leaders shifted away from considering vocational rehabilitation as a primary treatment goal (the chronic, often destitute alcoholic seen in the detoxification unit was an exception, of course).

For each of these groups of clinicians the comparison of followup status with community norms has made the data more meaningful; the mere statistical superiority of one treatment over another is considered less important than the degree to which each treatment enables clients to reach community norms of functioning. The community norms provide an outcome "yardstick" which makes comparison of cost to outcomes seem more reasonable. The initial enthusiasm in response to client outcome data presented in this way suggests that followup assessment can become a valuable aspect of community mental health program evaluation.

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