National Institute of Mental Health

Program Evaluation in the State Mental Health Agency

PROGRAM EVALUATION IN THE STATE MENTAL HEALTH AGENCY

Activities, Functions, and Management Uses

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

National Institute of Mental Health
Division of Biometry and Epidemiology
Statistical Program Development Branch
5600 Fishers Lane
Rockville, Maryland 20857

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FOREWORD

At the end of a very successful National Institute of Mental Health (NIMH) Annual Conference of the State and Territorial Mental Health Authorities in Dallas, Texas, in November 1973, the Mental Health Authorities made two specific recommendations to NIMH in the area of program evaluation. These recommendations were stated as follows:

(1) Consideration by NIMH of some method for systematic Federal-State and State-State sharing of evaluation developments, especially in the areas of goal description, criteria, and standards.

(2) Leadership by NIMH in bringing together the States which have developed advanced evaluation systems in order that these States may recommend to the remaining States basic strategies for evaluating service delivery systems.

It was this stimulus from the conference of Mental Health Authorities which resulted in NIMH contracting with the Southern Regional Education Board (SREB) to work with the 14 States of the SREB region to define more clearly the scope, functions, staffing, and management uses of program evaluation in a State mental health agency.

Some readers will not agree with all of the positions taken on the organization and use of program evaluation in the State mental health agency as expressed in this publication. However, we feel that this publication can be of valuable assistance to mental health programs at all governmental levels in all sections of the country in designing and administering evaluation programs. It is particularly timely that this publication appears during the implementation of new Federal community mental health centers legislation which requires a significant level of evaluation activity in all Federally funded community mental health centers. In all States there must be an effective State program evaluation role concomitant with the local CMHC evaluation activity. We hope that this publication will be but one step in a series of continuing activities to support the strengthening of program evaluation at the State level.

The knowledge, experience, and leadership of Dr. Harold McPheeters and the skills and dedication of Dr. Robert Heighton of SREB are evident throughout the pages of this document. In addition, the value of the consultation and technical assistance skills of the NIMH Project Officer, Mr. Cecil Wurster, cannot be overestimated. His contribu-

tions to the development and improvement of program evaluation activities in mental health systems are well known in the field.

Just as the State Mental Health Authorities stimulated NIMH to take action in compiling and disseminating evaluation knowledge, we hope this publication will encourage more State and local mental health agencies to incorporate evaluation activities systematically into their management operations.

Bertram S. Brown, M.D.
Director, National Institute of Mental Heatlh

James W. Stockdill
Director, Office of Program Development
and Analysis, National Institute of Mental Health

PREFACE

> *"Cheshire-Puss," she began, . . . "Would you tell me, please, which way I ought to go from here?" "That depends a great deal on where you want to get to," said the cat.*[1]

Like Alice in Wonderland, we need to know where we want to go, what methods are available to get there, and how well we are doing along the way (we don't want to get lost). When we arrive, we want to know if there was a better way we could have traveled so that we can use it on future trips.

Before we start off, we need to know exactly where we are. This includes not only our location in time and space, but also our reasons for making the trip and the values which directed us to choose our particular route and goal. Whether we realize it or not, all our subsequent value judgments depend on our initial philosophical assumptions.

Evaluation is a continuous process that takes place in all stages of a program. There are many doors through which program evaluation may be approached. The doors provide different perspectives of the program, and the best doors to use vary with the developmental stage of the program.

Program evaluation is a relatively new specialty within the State mental health agencies. There has been considerable uncertainty about what the agency might expect from evaluation and how it should fit into the management of the State mental health agency's overall operations.

The Southern Regional Education Board (SREB) obtained a contract (ADM-42-74-90) in 1974 from the Office of Program Planning and Evaluation of the National Institute of Mental Health (NIMH) to work with the 14 States of the SREB region to better define what the scope, functions, and staffing and management uses of program evaluation might be in a State mental health agency. We are grateful to NIMH for this support, particularly to Mr. Cecil R. Wurster, Chief of the Statistical Program Development Branch, Division of Biometry and Epidemiology of NIMH in Rockville, Maryland, for his assistance.

Many of the ideas and suggestions for this publication came from State level mental health personnel involved with evaluation who formed a Committee of the Whole and task force groups (see roster of members). This publication represents a committee effort and thus brings out a variety of perspectives on program evaluation. We thank the committee members for their contributions and their willingness to share their knowledge and experience in program evaluation. Whatever contributions to program evaluation that may result from this publication rightfully belong to them. We have written the final draft of this report and accept responsibility for what is found here, including any possible misunderstandings which might have resulted in translating their ideas. We also wish to thank Ms. Mary P. Wiswell and Ms. Paula Christy Smith of the project's staff for their assistance.

The committee effort brought together several perspectives on program evaluation that have been integrated into this whole, which, we hope, is more than the sum of its parts. Understanding the whole, we avoid the dilemma of the six blind men and the elephant:

And so these men of Indostan
Disputed loud and long,
Each in his own opinion
Exceeding stiff and strong.
Though each was partly in the right,
They all were in the wrong![2]

Robert H. Heighton, Jr., Ph.D.
Director, Mental Health
Program Evaluation Project

Harold L. McPheeters, M.D.
Director, Commission on Mental
Illness and Retardation

Footnotes

1. Carroll, Lewis. *The Complete Works of Lewis Carroll.* New York: The Modern Library, Random House, Inc., No. G-28, pp. 71-72.

2. Saxe, John Godfrey, "The Parable of the Blind Men and the Elephant." Fabun, Don, ed. *Communications: The Transfer of Meaning.* Beverly Hills, Calif.: Glencol Press, 1968. pp. 13-14.

ROSTER

(Committee of the Whole* and Task Force Members)

*Paul R. Ahr, Ph.D.
Department of Mental Health
and Mental Retardation
Richmond, Virginia

*William Aplin
Department of Mental Health
Montgomery, Alabama

*Ken Birtman
Division of Mental Health
Tallahassee, Florida

*David Bornman
Health, Social and Rehabilitation
Service Administration
Baton Rouge, Louisiana

Murray Bradley
Clayton-DeKalb Department of
Human Resources
Riverdale, Georgia

*Racine D. Brown, Ph.D.
Department of Mental Health
Columbia, South Carolina

*Robert L. Campbell, Ph.D.
Department of Health
and Mental Hygiene
Baltimore, Maryland

Robert W. Carrick
Department of Health, Education
and Welfare, Region IV
Atlanta, Georgia

*J. Frank Dearness, ACSW
Department of Mental Health
Nashville, Tennessee

Jack L. Franklin, Ph.D.
Division of Mental Health
Raleigh, North Carolina

Harris Goldstein, DSW
Florida State University
Tallahassee, Florida

*Richard T. Heine, Ph.D.
Department for Human Resources
Frankfort, Kentucky

*Kay Howard
Department of Mental Health
Charleston, West Virginia

Nicholas Louis, Ph.D.
University of North Carolina
Chapel Hill, North Carolina

*Dorothy N. Moore, Ph.D.
Department of Mental Health
Jackson, Mississippi

Dan Payne, Ph.D.
Department of Mental Health
and Mental Retardation
Richmond, Virginia

David G. Putnam, Ph.D.
Georgia Mental Health Institute
Atlanta, Georgia

Jacqueline Ransdell
Division of Mental Health Services
Raleigh, North Carolina

*Eugene Remes
Arkansas Mental Health Services
Little Rock, Arkansas

*Daniel M. Sheehan, Ph.D.
Department of Mental Health
and Mental Retardation
Austin, Texas

Martin Sundel, Ph.D.
River Region Mental Health-
Mental Retardation Board
Louisville, Kentucky

*Jean H. Thrasher, Ph.D.
Division of Mental Health Services
Raleigh, North Carolina

*James C. White, Ph.D.
Department of Mental Health
Nashville, Tennessee

William Wieland, Ph.D.
Division of Mental Health
and Mental Retardation
Atlanta, Georgia

*Cecil R. Wurster
National Institute of Mental Health
Rockville, Maryland

Alan Ziglin, Ph.D
Division on Mental Health
and Mental Retardation
Atlanta, Georgia

CONTENTS

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CHAPTER SUMMARIES AND OVERVIEW

Note. The Summaries and Overview will provide the reader with an index in outline form of the principal topics and subtopics of each chapter. These topics are not always worded the same as the headings found in the text; frequently they summarize the content of a single paragraph or a number of paragraphs.

Chapter I

An Introduction to Mental Health Program Evaluation

Background

Program evaluation in mental health has become increasingly important during the last decade, which has seen a great increase in Federal, State, and local appropriations for mental health. Funding sources, legislative bodies, professional groups, consumers, and the general public want to know how well the money is being used. During this time, critical reports of community mental health programs have been issued by the Nader group and the U.S. General Accounting Office.[1] One criticism made by these groups is that community mental health centers often operate with little or no program evaluation information to guide the administrators in managing their programs because of the inadequate outside evaluation which they have had to depend on and because of insufficient site visiting. Evaluation, particularly in-house evaluation, in the mental health field has been slow to develop.

In response to a growing concern for program evaluation, many State mental health agencies, departments, and programs have employed program evaluators or established an office of program evaluation in the agency's central office. However, the management uses of program evaluation in mental health—drug abuse, mental retardation, alcohol abuse, and mental health (hygiene)—have never been clearly defined and understood. Consequently, there is still considerable uncertainty about what program evaluators should be doing within the State agency and how they should relate to other central office staff and to the agency's field operations or to community mental health programs which may not be directly operated by the department of mental health, but for which the department has some evaluation responsibility.

The directors of the State mental health agencies are often clinicians who have come into administrative leadership positions with little or no particular training for program evaluation. Because of the administrator's specific training and skills, he has a limited knowledge of program evaluation. In general, evaluators, because of *their* specific training that stresses research and evaluation design and technology, are limited in their organizational and administrative skills.

Consequently, the administrator and the evaluator need to find sufficient common ground on which to meet.

Purpose of This Document

Broadly stated, this document is intended to help administrators understand and use program evaluation more effectively in the management of the State's mental health programs. This publication, prepared under a National Institute of Mental Health contract (ADM-42-74-90) with the Mental Health Program of the Southern Regional Education Board (SREB),[2] is intended for State level mental health administrators (e.g., commissioners, deputy commissioners, division directors, program evaluators) and for support units of State government (budget, personnel and merit system officers, board members, legislators) who make decisions about mental health programs.

The SREB Survey of Mental Health Program Evaluation (see appendix I) indicates that the staffing, organization, size, and plans for program evaluation of State mental health agencies vary widely. Thus, there can be no template for program evaluation in all the States. This is not a book on how to do program evaluation, but one which examines the evaluation process and suggests how an administrator can use it. In looking at how, when, and where an administrator uses program evaluation, this publication discusses four aspects of evaluation in the State mental health agency:

1. The *range* (scope) of activities which could be used in conducting evaluation. Chapter II looks at the extent and breadth of possible activities in the program evaluation process as part of the total evaluation responsibilities of the State mental health agency/program.
2. The *functions* a State agency might carry out to stimulate and assist program evaluation activities at all levels of the department. Chapter III explores the responsibilities of the State agency in encouraging evaluation in the individual programs, since it is impossible for the State to do all evaluations.
3. The *organization and staffing* of program evaluation within the State mental health agency. Chapter IV looks at alternatives for staffing and organizing program evaluation, and examines possible informal relationships between the central office program evaluators and other departmental units and field operations.
4. The *relationships between management and program evaluation* that will enable administrators to make the most effective use of evaluation. Chapter V explores ways in

which the administrator and program evaluator working together can make program evaluation an integral part of the management process.

What Is Evaluation?

While the word "evaluation" is widely used, it is also frequently misused and misunderstood. Evaluation is not new. The mental health agencies have in the past made judgments about their programs and services. Program managers have always made intuitive judgments concerning resource allocations and program worth. The need today is to be somewhat more objective and systematic in approaches to program evaluation.

In this publication, mental health program evaluation is defined as *the process of determining the results of programs and analyzing the extent to which they have accomplished their predetermined goals and objectives.* Theoretically, program evaluation is concerned with outcome and impact. Although this is the ultimate goal toward which mental health evaluation is moving, it is not always practical because many programs are still in the early stages of development and administrators need information *now* to guide their programs. When programs are better established, program evaluation should be more oriented toward results.

Because administrators now need *systematic* information to make program operating decisions, the evaluation process continuously monitors and feeds back information for correcting and improving the program's course.

The evaluation process involves determining the program components and operations requiring study, selecting the appropriate techniques for gathering data, and collecting, analyzing, and presenting the information in the most useful way for the administrator. In doing an evaluation, each program must be approached as the unique dynamic interacting system which it is. To be useful to an administrator, an evaluation must consider the unique variables the administrator has to deal with. Therefore, a person evaluating a program for management purposes needs to be highly innovative and sensitive to the administrator's needs, and not restricted to rigid, textbook methods and designs.[3]

As in any new and developing field, the definitions and basic concepts are hotly debated. But while some only sit and discuss, others take the idea and run with it. For example, some theoretical aspects of electricity have never been fully defined, but look at all the uses we have put it to!

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Some classical experimental and quasi-experimental evaluation designs now in use may be more appropriate at the national policy-making level than at State and local administrative levels. The problem with these designs is that they use unilinear thinking that stresses causality. These designs, which use independent and dependent variables, attempt to control for variables which are seldom controllable in ongoing program operations. This kind of design is appropriate for evaluating pilot programs which are new and are being tested under controlled conditions.

However, the manager of a State level mental health agency is almost never able to hold constant his program variables, such as resource inputs and the program inputs of his agency. Revenue shortfalls, freezes on hiring staff, unexpected increases in admissions of clients, etc., put the administrator in the position of having only a host of "depending" variables—not the classic experimental situation in which all variables are controlled except the one being evaluated.

The thinking needed in doing an evaluation is that which an ecologist might use in describing the interrelationships of an open system. It must be able to explore pathways and relationships which may branch off and interlace in this evolving and changing system, not just those which proceed along straight lines to set outcomes. The important thing to understand is that a system is not outcomes. The interrelationships of the system and its self-corrective monitoring and feedback mechanisms must be used for program improvement.

Management Needs and Evaluation

Management needs for program evaluation will vary according to the perspective from which evaluation is viewed. For example, the degree of detail required in the evaluation of various programs may differ; the evaluation may be done at different stages of programs; all or part of the program may be examined; the evaluation may be performed by an evaluator external or internal to the program; and the interpretation of evaluation results may vary according to their intended use. Also, the philosophies (values) which support and influence the program and its evaluation will vary depending upon the professional, social, organizational, and personal philosophies of those involved in the program. The evaluator must also be sensitive to his own philosophies so that they do not unintentionally bias the evaluation results.

Any one of these possible variations can influence the research design and the types of data collected, the analysis of the data, and the form in which the results are presented. These variations will

determine whether the evaluation is highly structured or informal and whether it is external or internal.

External evaluations are those performed by outside consultants or research organizations which ideally use scientific techniques and measures in an attempt to perform an objective and unbiased evaluation. They may be requested by State legislators, State departments of administration, mental health associations, or professional associations. The standards, objectives, and measures used by outside evaluators may or may not be those of the program being evaluated. Although external evaluations are often considered a threat and have occasionally been used for witch hunts, they can be useful to the administrator if they are timely, contain positive recommendations, and provide him with an outside view of his program.

However, external evaluations or activity arising out of crisis situations may be perceived as criticism and may create a defensive atmosphere in the program or agency. Furthermore, external evaluations may be based on philosophies or standards different from those of the program, or the program may have difficulty articulating its philosophic, political, and social values. Organizations outside the program, when reading the evaluation report, may interpret program results differently because of *their* varying philosophies.

The primary need of the State mental health administrator is for regular internal program evaluation which is oriented to his value system and which provides sufficient recommendations for him to guide his program to its explicit or implicit objectives and goals. Internal evaluation can be either self-evaluation (i.e., that conducted by program or facility staff on themselves) or inside evaluation (i.e., that conducted by the State mental health agency).

The scientific activities of internal evaluation range from highly rigorous and elaborate to informal and hasty, but each should involve systematic analysis of data with recommendations for decision making by the administrator who needs the information to manage his program effectively and efficiently. Early in a program, the manager needs a continuous flow of information which tells him whether the program is operating within acceptable limits and whether it is following its objectives toward its goals. Thus, evaluation at this early stage will be simple and strongly oriented toward monitoring and sensing "problems" or deviations that need correction. Later, when the program is better established, evaluation should be more thorough and oriented toward results. Even then, however, the administrator must be concerned with costs, efficient use of resources, and process as well as results.

What the mental health administrator needs from the program

evaluator throughout the life of his program is systematic and objective information which tells him how well his program is meeting its objectives, detects program changes that may not be readily noticed, and presents the information in a way he can use it to modify and correct his program.

The State mental health agency administrator's position is analogous to that of an admiral commanding a fleet of merchant ships, and the evaluator is his navigator. The admiral needs chart information, a voyage plan, a clearly defined destination and mission, and a specialized crew to help him steer his ships to the port of delivery as efficiently as possible. The admiral's information will come from many sources: the ship captains' reports on the conditions of their crews and ships, the quartermasters' reports on supplies, etc. One of the admiral's essential crew members is the navigator, who takes continuous course sightings, forecasts possible difficulties (e.g., administrative storms, judicial and economic icebergs, and changes in the Federal tides and the winds of public opinion), and plots alternate courses. The navigator takes sightings and plots corrections in relation to the fleet's destination. Therefore, he must know the destination and why and how the admiral had planned to reach it. The admiral's techniques for monitoring his information will vary with the stage of the voyage and the fleet's progress compared to the plan.

Uniqueness of Program Evaluation

The social, economic, political, and time pressures under which State mental health programs operate force an administrator to be primarily oriented to the present and near future. By focusing on objectives, outcomes, and impacts, program evaluation adds a necessary long-term orientation.

The main functions of the administrator are planning, organizing, staffing, directing, and regulating (guiding like an autopilot or regulating like a thermostat). To paraphrase Ross, regulating enables a program to adhere to its plans. Thus, it (a) sets standards of performance in order to reach the objective, (b) measures actual performance against these standards, and (c) corrects deviations to assure that actions remain on course.[4] Regulation does not imply static goals and objectives because systems do radically change and goals and objectives must be able to change with them. *The administrator is the prime evaluator.* But because of the administrator's comprehensive responsibilities, he needs specialized support staff to carry out activities such as planning, staffing (personnel), and regulating (accounting and evaluation).

Program evaluation uses knowledge from the areas of statistics, research, planning, management, etc., but it is unique because it views a program from various perspectives in a total context, and examines the program with an open mind. Program evaluation combines the information gathered, compares and judges it, and views it from the perspective of results within an objective, analytical, and systematic framework.

Footnotes

1. Musto, David A., Whatever happened to community mental health? *The Public Interest*, 39: Spring 1975.

2. The Mental Health Program of the Southern Regional Education Board (SREB) has a contract (ADM-42-74-90) with the National Institute of Mental Health (NIMH) to assist the 14 States in the SREB compact organization in improving State level evaluation of their mental health programs. This contract requires the preparation of a document that will provide guidelines on scope, function, structure and staffing, and the management uses of program evaluation within a State mental health agency. It also requires a survey of the program evaluation activities of the State mental health agencies at the start of the project and for two workshops on topics of general concern to the State mental health program evaluators.

3. As reported in *Behavior Today*, February 10, 1975, p. 383, Stanford University education professor Lee Cronbach believes that trying to set up all-purpose evaluation techniques is a mistake. "It is inappropriate to apply uniform methods to programs intended for various purposes, especially when a particular test can serve some purposes well and other purposes badly." He points out that "evaluation is a function performed within a system that is largely political. Hence an evaluation is to be judged by its effect on the working of the system, not by its internal scientific rationale alone." Cronbach points out that another problem is that "technical devices now available to the evaluator have originated in contexts rather distant from evaluation." They may make important contributions to an evaluation, but at other times, a procedure recommended on technical grounds is counterproductive. In evaluating a program, Cronbach says, "it is critically important to investigate what is actually delivered and by whom it is accepted as well as to assess outcomes."

4. Ross, Joel E., *Management by Information System*, Englewood Cliffs, N.J. Prentice-Hall, Inc., 1970. p. 183.

Chapter II

Range of Program Evaluation Activities

This chapter is an overview and brief description of the scope of the many activities involved in monitoring and evaluating programs for which a State mental health agency has or might assume responsibility. Some of the activities that could be used for evaluation are presently being carried out, but the data they generate have been used primarily to fill out reporting forms sent to the Federal Government, or to prepare annual reports, or to answer specific requests from legislators, State auditors, citizen groups, or the press. The data are rarely analyzed and used for evaluation purposes. This chapter points out some of the ways in which the activities and data can be used for evaluation.

Evaluation in a Program

Evaluation is a continuous, ongoing process that takes place in all stages of a program. It should *not* take place *only* after a program is fully operational; program evaluation should be used in the planning and daily operational stages of a program as well as in its assessment stage.

Planning Stage

1. Assessment of needs and expectations

An assessment of the target population's needs and expectations is done during the planning of a program and before its development and implementation. Needs assessment is not generally considered a program evaluation activity, but is usually done by planners if it is done at all. If it has not been done, those responsible for evaluation must see that it is done or do it themselves in order to have a data base for eventual evaluation of the program.

- The *assessment of needs* revolves around questions about the incidence and prevalence of the problem, basic demographic data, special aspects of the population (social, ethnic, and cultural data that might not appear in census data), projections of the probable demand

for the services, and information about existing area programs that already meet part of the need. These data are used in conjunction with the administrator's value judgment to decide program priorities, size, location, and specific characteristics.

There are many technological approaches to assessing needs (e.g., epidemiological studies, door-to-door or telephone surveys, surveys of community agencies).[1] At times there is a tendency to spend an extraordinary amount of resources on technical surveys and give very little attention to the probable demand for actual services. It should be the evaluator's job to help the administrator focus the assessment to provide the greatest amount of pertinent data for the least resources. If the evaluator is brought in at this early stage of the program, he will be familiar with the social, economic, and political values which helped shape the program and which later will affect his evaluative interpretations and recommendations concerning the program. Still later, during the operational stage of the program, these data will enable the evaluator to assess outcome and impact.

- *Information about the expectations* for the program that are held by potential clients, members of advocacy groups, political leaders, local community members, professional associations, mass media, etc., is gathered by the planner or evaluator in the planning stage. Later in the program, the administrator may ask the evaluator to assess whether the expectations of these groups have been met.

The expectations of various community groups may differ from each other and from actual needs. For example, some local citizens may see a planned mental health facility as a threat to their neighborhood; others may see it as a job opportunity; and a nearby university may envision it as a major teaching resource.

2. Setting objectives and goals

One of the most important program evaluation activities in the planning stage of a program is helping the administrator to *clarify and define the program philosophies, objectives, and goals* in explicit terms that can later be used for program evaluation. This has seldom been done in the past. Too often evaluators are called in after a program has been in operation for some time, only to find that there has been no clear definition of goals against which the evaluator can evaluate the program.

- Setting objectives and goals should include a written *statement of the program's philosophies.* Often this step is omitted altogether, but it has serious implications. A statement of philosophies makes explicit the set of values upon which the program will rest. It is philosophy that accounts for the difference between one clothier

which caters to the carriage trade with high quality clothing, and another which sells medium-priced, mass-produced clothing to a wide segment of the ordinary public, despite the fact that both companies are in the same business with otherwise similar goals and objectives.

In the field of mental health, philosophy determines the difference between a program that renders only the highest quality of service to a small number of clients and a program that attempts to provide a reasonably adequate level of service to as many clients as possible. The former is the typical philosophy of private hospitals and private practicing professionals; the latter is the philosophy of most public mental health program administrators.

Problems can arise when an agency *assumes* that a program should provide some minimal level of care to as many persons as possible, and a therapist in that program assumes he should provide high quality care for only a few. An evaluation of a program with this built-in but unstated assumption will question the efficiency and worth of people with the therapist's assumption. An adversary position between the administration and the therapist could result if the therapist feels he is being forced to lower his professional standards. It would be much better if the differing perspectives were brought out at the beginning of the program's development.

Value issues in mental health include: whether the program is striving for social functioning of its clients or the removal of psychopathology; whether client dignity and freedom are important values or regimentation and standardization of meals, clothing, etc., are acceptable; and whether the program is committed to—or against—any particular model (e.g., medical, behavioral, or social) or procedure of treatment (e.g., psychoanalysis, electroconvulsive treatment, psychopharmacology, group therapy, milieu therapy, therapeutic community). From the very beginning, the program evaluator should help the administrator make the program's philosophical commitments clearly known both for administering the program and for doing program evaluation.

- After the philosophies are set, *objectives and goals should be clearly stated* as precisely as possible. Again, the evaluator *aids* the administrator. There is disagreement about the appropriate terminology to use for this process, but not about whether it should be done. To some people the term "objective" is used for the expected outcomes of an overall agency or organization. Thus, an objective of an overall community mental health center might be to reduce the prevalence of mental disability in the catchment area by 20 percent in 5 years. The term "goal" is then used for the outcomes of specific

programs. Thus the goal of the alcohol detoxification program of that same community mental health center might be to restore 100 alcoholics to alcohol-free physical health in the next year. Other persons use the terms "goal" and "objective" in reverse order. In either case, all of the goals and objectives should be described as sharply as possible—with specific measurable amounts and specific target dates. This is much easier to do for those programs that serve individual clients and much harder, but not impossible, for those programs that try to change the community's practices, public attitudes, or large agencies' policies.

• When the administrator and evaluator define the program's objectives and goals, they *decide what criteria measures are to be used to evaluate* whether objectives and goals have been reached. For example, what criteria will be used to decide whether alcoholics have been restored to alcohol-free physical health? Their own statement? A relative's statement? A physician's examination? If these criteria have been set, it greatly helps the person doing an evaluation.

To have the philosophies, objectives, goals, and criteria measures agreed upon at the very start of a program is an ideal situation. However, many programs already underway within State mental health agencies have never had these defined. The programs have been set up and operated on a largely intuitive basis. At this time there is tremendous need for program evaluators and key program administrators to take time to go through this process for the existing programs. This would provide a base for future program evaluation. The process should be reviewed every few years as philosophies, public policy, and technology change over time and require a fresh or modified set of objectives and goals.

Daily Operational Stage

1. Basic data

• The central office's primary need in daily program operation is *basic descriptive data on the various facilities and programs* of the State. The evaluator also works from this data base and, in conjunction with the administrator, can be responsible for seeing that it exists. This inventory of facilities and programs can include client capacity, facility census, demographic characteristics of the clients, staffing patterns, descriptions of programs offered, buildings, budgets and expenditures by major items, etc. The descriptive data is used by the administrator for annual reports, news releases, and presentations to legislators and budget officials. It is also useful for reviewing program priorities and making budget and staff allocations.

• To allocate funds and staff, delegate authority, communicate decisions, and set program priorities most effectively, the administrator *needs to know both the formal and informal relationships* between various units of the agency, as well as their *processes and procedures*. The program evaluator also needs this information to perform an accurate and effective evaluation. The information both need can be provided by an organizational analysis, which deals with the *modus operandi* of the organization rather than just its basic structure and objectives.

2. Program monitoring

Basic facility and program data, results of organizational analyses, needs assessments, objectives, goals, and philosophies are some of the basic data that are increasingly being incorporated into computerized *management information systems* (MIS), which can also be used for program monitoring.

• It is administratively necessary to *keep the basic data base up to date* and to have someone monitoring it so that significant changes can be detected quickly and appropriate changes made in programs. If there is a smoothly running, computerized management information system, it may be easier to keep much of the data base up to date. Administrative data which must be current include client census, admissions, staffing, expenditures, and program activity. In a well-functioning, computerized MIS, many managerial functions can be automatically taken care of by the computer (for example, the amount of food to be ordered will be adjusted according to the current population in residence).

Although the future use of the MIS in monitoring looks promising, most agencies presently don't have this MIS capability and must depend on their program evaluator to continually assess data on program activities, progress, resources, and demands, and to detect and report deviations from program goals, plans, or procedures. Even with a complete MIS, it will still be necessary for the evaluator to assess and evaluate the information.

Understanding monitoring, the evaluator should work with the program's administrator and statistician to determine what currently collected data he needs and what new data are needed so he can effectively tell the administrator how the program is running, what changes are occurring, and what trends are appearing. A program evaluator plays a needed and useful role by *monitoring* changes in the basic data reports and bringing significant deviations to the attention of the administrator and the management team. This requires him to *scan and interrelate* all relevant program data (e.g.,

patient admissions and movement data, seclusion and restraint records, expenditure reports, staffing changes, etc.) to detect such things as rising admission rates, unused bed capacity, and changing release rates. Evaluation thus serves as an important sensing mechanism to detect potential problems early and modify programs to meet changing needs.

- The *use of standards* is another aspect of monitoring with which the evaluator can help the administrator. (Standard: a state or condition accepted as a minimal or exemplary condition, appearing in law, regulation or policy).[2] Monitoring of standards is primarily concerned with quality assurance. In the past 5 years, there has been a great surge of concern about clinical services of all health and mental health programs which has been prompted by third party payment programs and concern for costs, quality of service, and accountability. Standards are an attempt to answer these concerns. Most States, as well as various Federal and national organizations (e.g., National Institute of Mental Health, National Institute on Drug Abuse, National Institute on Alcohol Abuse and Alcoholism, Developmental Disabilities Administration, Joint Commission on Accreditation of Hospitals, etc.) are formulating standards.

There are generally three types of standards:[3]

1. *Input* standards are those that spell out the basic resources required for the programs. These include such items as building standards (e.g., 180 square feet per patient), staffing ratios, staff qualifications in training, licensure and certification, and equipment standards.
2. *Process* standards are those which define the procedures to be used in the clinical services (e.g., "Every patient shall be examined and given a tentative diagnosis by a physician within 24 hours of admission." "Medications will be given only by or under the direct supervision of a registered nurse.")
3. *Outcome* standards are those that spell out the client outcomes to be attained. Outcome standards would be most ideal from the perspective of the program evaluator, but they are rarely used because it is difficult to develop outcome standards in human service work.

Usually there are special persons or teams that do the actual monitoring of the standards. Periodically the program evaluator should review the agency's experience with monitoring of standards. Such a review will detect compliance problems and other areas that need to be brought to the attention of the program administrator for modifications. Just as the evaluator should be involved in planning

a program, so should he be part of *standards setting* if he is to be most useful to the administrator. The evaluator should point out to the administrator the relationships of the variables (e.g., pharmacy, nursing, group therapy, chemotherapy, etc.) within a program's component services (i.e., in a community mental health center—inpatient care, outpatient care, emergency care, partial hospitalization, consultation and education) and the relationships among the components so that the administrator knows the parameters within which standards should be set.

Once the administrator has this specific information, the evaluator can help him decide how to measure the standards, what criteria to use, and what techniques are most appropriate to use with the criteria. He should help the administrator and others responsible for standards determine if the program is currently in compliance with the standards, what new standards might be coming from Federal agencies and national organizations, and what standards conflict with each other.

Various techniques (e.g., paper forms, site visits, utilization review, peer review, etc.) can be used to monitor standards. Review of paper forms filled out by the program or facility can become a ponderous burden unless the monitoring is done by reviewing records already being kept. Site visits are likely to be more acceptable; they give an opportunity to observe program-specific needs and provide consultation and technical assistance.

- *Utilization review* monitors and evaluates the appropriateness and use of a program's services. It is applied to assure that persons are not hospitalized unnecessarily or kept in the hospital longer than necessary. Here, too, the standards are set and reviewed by special committees or staff, but the program evaluator can help in setting those standards and in periodically looking over the results of the utilization review committee's actions to determine whether there are overall utilization problems within the program and to report these to the administrator for corrective action. His analysis might also determine that there is need to modify the standards used by the utilization review team.
- *Peer review* is a mechanism for evaluating treatment and rehabilitation procedures by a formal review of medical records by a team of peers. It is a quality-assurance device which now relates specifically to the medical-psychiatric treatment services in mental hospitals.[4] However, it is likely that peer review will soon extend to other professional services and to other mental health settings.

Until recently peer review was done only when a complaint was filed as a result of an excessive fee or a poor outcome. Now with the

great increase in third party plans and Professional Standards Review Organizations (PSRO's), there is increasing pressure to set and monitor standards for all treatment cases. Under PSRO, all clinical activity will be monitored and reviewed according to clinical criteria set by peer practitioners. The review may be done by peers within the specific facility or by an organization of peers in the community (a PSRO). In either case the mental health program evaluator might be involved in helping set the original criteria and in periodically examining the peer review actions of the program's treatment services to detect problems or trends in both the program and the peer review process that should be brought to the attention of administrators for corrective action. (For example, analysis of peer review activity may reveal that the physicians need special training regarding certain medications or that the hospital should be purchasing a different sized tablet of certain medications.)

- *Setting and monitoring of "quality of life" standards* pertains to the quality of life for clients in the institutions or programs of the agency. It relates to institutional dehumanization of patients and considers whether clients have privacy, free choices, and dignity; whether they have an esthetic and humane environment; whether they are treated with respect and their records kept confidential; whether they have decent quarters, meals, clothing; and whether they are given opportunities for recreation and spiritual fulfillment.[5] Increasingly, court suits are being successfully prosecuted in instances where such considerations have never been defined or monitored.

This is an area in which the program evaluator might be of real help in defining the criteria for quality-of-life standards. The evaluator can also be involved in periodic review of the quality-of-life monitoring to detect practices or problems that should be brought to the attention of the administrator for appropriate program modification. (For example, if it is discovered that *all* patients on a geriatric service are being addressed by their first names, the administrator may want to issue a memorandum to all staff about patients' preference for use of their names.)

Assessment Stage

After a program has been fully operational for some time or is completed, the evaluator and administrator are primarily concerned with results. This concern is traditionally identified with program evaluation. In determining a program's results, customary program evaluation activities are generally used.

Outcome studies let the administrator know how well and to

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what extent the programs have met their goal and if there are any unanticipated outcomes. For example, the program that had a goal to return 100 alcoholics to alcohol-free physical health may actually have returned 120 alcoholics to health—120 percent of its goal. It may also have restored 35 of them to productive employment, a result that was not anticipated for a detoxification unit. There is a wide range of research designs and methods available for outcome studies, but all basically depend on the program's having set specific goals and criteria measures at its beginning.[6]

Impact studies analyze the relationships of the program outcome and activities to the original need and to any related consequences. Related consequences may be economic, social, political, or clinical. Because they go beyond immediate outcomes, impact studies are one of the more comprehensive evaluation techniques for letting the administrator know the total effect of a program.

Impact studies are difficult to design, implement, and interpret. Theoretically, they imply a causal relationship between an agency's activities and the social well-being of a community. Methodologically there are numerous design problems, chief of which is the intrusion of factors beyond the control of the agency involved in providing services. Many powerful forces at the community, societal, and cultural levels work against the success of human services programs, e.g. mobility, migration, economic fluctuations, changes in national policy, demographic changes within the community, altered physical or ecological patterns.[7]

In the example of the alcohol detoxification program given above, an outcome study indicates that the program surpassed its goal by 20 percent. If the reported incidence of alcoholism in the community or the number of drunk-driving arrests decreased during this same period, the program would appear to have had an impact on the need. However, attributing the decreased incidence of reported alcoholism to the program may be spurious. Other factors may account for all or part of the decrease. For example, the police may have shifted their law enforcement efforts from drunk driving to other areas or a dry law may have been passed.

Cost analysis studies analyze how program expenditures are allocated. Essentially, costs are figures derived by examining expenditures of funds according to various criteria that are felt to be meaningful. Many different cost figures can be derived from the same set of expenditures (e.g., cost per patient per day, cost per live discharge, cost per patient year). These costs can then be analyzed and comparisons made between similar programs, between successive years, between different models of treatment, between different patterns

of organization, etc. Cost studies of this kind are valuable to the administrator in setting priorities, making program changes, and preparing budgets.

It has been common for cost studies, when they have been done at all, to be done by the business office with very little relationship to the clinical programs. The studies have thus tended to be concentrated in the business area only (e.g., costs of food, maintenance supplies, equipment, laundry services). The mental health program evaluator can serve a significant role by helping derive cost analysis studies related to clinical program items (e.g., costs of treatment, costs of aftercare, costs of rehabilitation, costs of crisis services).

- *Cost-benefit analysis* compares the cost of a particular effort with the benefits obtained from it. It attempts to assign monetary value to benefits and then divides this figure by the cost in dollars. Presently, determining benefits and assigning monetary values to them is much more an art than a science because it is very difficult to describe social benefits in common monetary units. Economists readily agree that the techniques for assigning monetary values to social benefits are not yet firmly defined.[8] Cost-benefit analysis is generally used now as a projective tool to assess the relative effectiveness of proposed program alternatives. Although economists may disagree and the technique is basically projective, it may still be useful to the evaluator and administrator in assessing present and past benefits and costs of the program.

There have been attempts to develop cost benefit ratios such as "costs per live discharge" or "costs per client restored to independent social living." Other examples of cost-benefit studies in mental health are (a) studies to show whether it is more economical for the State to provide medications and aftercare services for former State hospital patients or to turn this responsibility over to local communities, or (b) studies to evaluate whether long-term care of the mentally ill is more economical and more effectitve in State hospitals or in nursing homes. But comparing the ratios may be questionable since the programs may not serve the same populations or have the same predetermined goals.

- *Cost-effectiveness studies* are a limited version of the cost-benefit technique which attempts to specify and evaluate social costs and benefits of different programs and services that have *the same target population and identical predefined goals.* "Since the target problems are the same, whatever measurement of benefit is applied to one group is applicable to other groups. For example, if one group of neurotic depressives receives psychotherapy alone and another group of neurotic depressives receives drug therapy alone,

the measures of treatment relevant for one group—decreased depression and improved family relationships—are as relevant for the other group." [9] Therefore, cost-effectiveness studies are less vague than the more general cost-benefit data and so allow the administrator to feel more confident when judging alternatives. They are a form of evaluative research rather than everyday program evaluation.

Although cost benefit and cost effectiveness are plagued now by many questionable assumptions, these analytical techniques should be further developed. In the meantime, the administrator can gain from these techniques some insight relating costs and benefits that will help him know how to better allocate his resources and make choices about program priorities.

Client satisfaction studies analyze the opinions, attitudes, and reactions clients express about the services received from a program. These studies tell how the program is meeting the expectations and needs of the clients, their families, or referral agencies. There are various techniques (questionnaires, personal visits, telephone interviews, etc.) to evaluate whether these people feel they have been well served, what problems or shortcomings they have experienced, and what suggestions they may have for improving the services. The evaluator should also be alert to specific suggestions made by individuals on client satisfaction studies for these suggestions may provide leads for significant extra improvements in programs.

Special studies may examine areas where there are no routine data collection and analysis activities or where routine analysis indicates a need for further study. Also, it may be that certain studies are needed only at periodic intervals (e.g., studies of staff time commitments to specific activities). Other studies are required only one time (e.g., to supply information for an investigation exploring charges that have been made against some specific aspect of the program). Special studies may be drawn from the overall data base already in the files in the central office, but at other times they will require an entirely new data gathering effort. Very frequently there is some blend of the two. Special studies may be done on managerial functions (e.g., costs of central purchasing compared to decentralized purchasing) or on clinical problems and programs (e.g., analysis of a rising suicide attempt rate or of an increasing rate of seclusion and restraint in certain program units).

The need for doing a special study should ordinarily be prompted by the monitoring function of the program evaluator who senses a need or problem that requires special study. However, special studies may also be prompted by curious individuals within the agency's staff, by the administrator himself, or occasionally by charges brought

by the press, citizen groups, clients, etc., which require a special study as part of the investigation.

Footnotes

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Chapter III

Program Evaluation Functions in the State Mental Health Agency

Chapter III discusses the functions of a State office of program evaluation by describing that office's role in fostering and promoting evaluation within the agency. The State mental health agency has responsibility for a large number of programs, including the State mental hospitals, State institutions for the mentally retarded, State operated alcohol and drug abuse clinics, and any State operated mental health centers. It may also have evaluation responsibility for community programs in mental health, mental retardation, alcoholism, drug abuse, or aftercare which receive funding or technical assistance from the State. Within each of these facilities there are dozens of individual programs (e.g., intake, treatment, rehabilitation, alcohol or drug detoxification, geriatrics, early case detection, day care, primary prevention, and consultation and education).

It would be naive to assume that a single person or office in the State mental health agency could be expected to actually carry out the many evaluation activities identified in the previous chapter. Therefore, this chapter will examine some of the realistic functional roles for a State mental health office and the functions that an administrator can expect his program evaluation staff to carry out in regard to the overall evaluation mission of the State department or division. Although this may occasionally include State evaluators performing an evaluation, the State office will generally be involved in encouraging and supporting local programs to develop their own evaluation ability. The functions discussed here are not given in a priority listing.

Evaluation by the State Agency

In producing *an overall evaluation of the aggregated programs* within the division or department, State level evaluators may carry out any of the activities described in chapter II. For example, the department may wish an evaluation of all the mental hospitals or all the community mental health centers. This could also include Statewide comparisons of similar programs.

The State evaluation office may provide the agency administrator with ongoing *audit/review of the agency's facilities and programs.* This monitoring function might include alerting the agency administrator to deviations or changes in admissions, resources, etc., within the State hospitals, institutions, centers, clinics, programs, etc. For example, the State evaluator, through monitoring statistics and reports, might find admissions of children or alcoholics have greatly increased, or that certain kinds of patients are staying in the hospitals longer than usual. These changes should be reported to the management team for their program decisions.

Checking for the existence of realistic objectives and goals that can be measured might be another function of the State office. It could report which programs meet the criteria and which might need assistance. The State evaluators can also *check data* provided by programs to assure the administrators of their validity and reliability.

The State evaluation office may have the responsibility for *evaluating the State agency's central office and any technical programs it might conduct.* For example, the State office may evaluate the department's film and pamphlet library, its technical services, and management procedures of the central office.

To facilitate the use of evaluation information in management decision making, the State evaluation office might *take the initiative to bring program evaluation findings to the attention of members of the mental health department's management team.* This would include maintaining communications concerning program evaluation findings with the directors and deputies of such divisions or departments as the commissioner and his deputies, planning officers, business administration staff, professional services staff, and manpower or staff development office.

Assisting Field Agency Staff

The State evaluation office can *develop program evaluation modules and materials* that can be used by persons in the programs. For example, the staff of the central office might prepare kits of survey forms, procedures, and instructions for community mental health centers to use in assessing the needs for programs or they might design the forms, instructions, etc., for mental hospitals to use in evaluating their aftercare services.

Because evaluation is an essential function of management at all levels, the State staff may also *aid the field operations in establishing their own program evaluation units.* This might involve assisting local administrators in defining the functions and activities to be carried out by such a local program evaluation unit (e.g., identifying staffing

requirements, writing job descriptions, developing tables of organization for program evaluation, etc., and recruiting and orienting program evaluation personnel).

Consultation to field agency staff can be provided on request *to help design specific program evaluation studies* (e.g., a social worker in a crisis center might want help in designing a study of calls about suicide), and to make local program evaluation more useful to the local manager (e.g., the local administrator might ask the central office to consult with his program evaluators on ways to make their evaluations more useful to him).

The State evaluator might *evaluate the program evaluation efforts of the local programs* at the request of the local administrator or perhaps as a regular function of the central office.

Technical aid for local program evaluation might come from the State evaluation office. The State office might also assist local programs in obtaining technical aid from other sources. This could be done by providing bibliographic references, helping local programs obtain statistical services, or aiding them in locating consultants for local evaluation.

Communication, Coordination, Liaison

The State office of evaluation can *serve* as a *communication and liaison mechanism* to provide field staff with information and access to various techniques, concepts, and resources. In the rapidly developing field of program evaluation, it is virtually impossible for any one person to keep up with all developments. The State office might help field programs keep up to date on evaluation activities through an agency-wide newsletter devoted to evaluation, evaluation articles in the agency's newsletter, and a listing of available evaluation reports on local programs. A newsletter might give an annotated bibliography of new concepts and techniques appearing in evaluation literature and/or presented at professional conferences.

Coordinating mental health evaluation efforts throughout the State by scanning evaluation activities in the State and putting persons working on similar problems in touch with each other is another function of the State office of evaluation. State level evaluators might also coordinate mental health evaluation activities relating to certain aspects of program evaluation operations in the department with other units of State government, such as the budget division or merit system.

To *stimulate program evaluation in local mental health programs,* the State evaluation staff could set up a *statewide evaluation committee* of interested representatives from local programs that would

meet to exchange experiences, problems and solutions about program evaluation. The State staff could also give *presentations on evaluation* during meetings of local administrators or hold special workshops featuring the use of evaluation in program administration. Or, *workshops* could be conducted for other department personnel on topics such as the design of evaluation studies, specific evaluation techniques (e.g., Goal Attainment Scaling), or use of computers.

Acting as liaison between program evaluation operations in the State department of mental health and evaluation activities in other major agencies might involve liaison with:

1. evaluators in other departments of State government. These might include departments of human resources, health, welfare, vocational rehabilitation, and corrections among others;
2. university programs (especially those teaching program evaluation and mental health administration);
3. regional programs such as the Southern Regional Conference on Mental Health Statistics, the Southern Regional Education Board, or the Western Interstate Commission for Higher Education;
4. Federal agencies such as the National Institute of Mental Health or national professional organizations.

Manpower Development

Stimulating manpower development of program evaluation personnel at professional and technical levels is another important function that the State office of evaluation might carry out. The State office might take the initiative in encouraging and assisting universities to set up training programs for various levels of program evaluation personnel. These might be doctoral or master's degree programs, or short-term continuing education programs for people already in the field. The State office might also assist in planning training programs to assure that the appropriate skills and values are stressed so that the graduates will be able to carry out practical and useful evaluation in State and local mental health agencies.

Determining the Functions for State Program Evaluators

The administrator must decide which of the many functions discussed in this chapter he wants his program evaluation staff actually to carry out. These decisions will vary with:

1. the stage of development of the State mental health agency itself;
2. the size of the State's mental health program;

3. the overall role of the State office in regard to the operating programs;
4. the personalities and competencies of the evaluators on the staff; and
5. the size of the program evaluation staff.

In some States the central office is expected to offer considerable leadership and stimulation to the field operations and to local community mental health programs. In this case the program evaluators will probably be given a larger number of these functions. In other States the central office is expected to serve mainly as a collecting point for budget requests, personnel requests, etc., that are being transmitted to other agencies of State government. The central office of mental health is not expected to exert much leadership in regard to the local operations. In these cases the entire central office is likely to be small and to have few program evaluation functions.

Chapter IV

Organization and Staffing for Program Evaluation

This chapter explores some of the alternative organization and staffing schemes for program evaluation within the State mental health agency. There is such a great variation in the ways in which State mental health agencies are structured and staffed that it is impossible to offer any single plan for the organizing and staffing of program evaluation. However, there are some alternative patterns that can be considered.

The three major areas examined in this chapter are organization, staffing, and evaluation's functional relationships to other units of the department.

Organization

The organization of program evaluation within a State department of mental health will reflect the agency administrator's decision on the range and functions of program evaluation. It also depends on the resources available (e.g., computerized data systems) and special demands that are being made on the department (e.g., a large human resources agency may require reports in a "Management by Objectives" format).

Ideally, every facility, program, institution, etc., will have some program evaluation capability. This is not always feasible, however. When there cannot be evaluators for all programs, it is recommended that program evaluation resources be *relatively* concentrated at the higher decision making levels. However, it is not desirable to have *all* evaluation done by the central office of the agency.

Among the alternatives available for organizing program evaluation in the central office are the following:

1. No specifically designated program evaluators
2. Outside program evaluation by private organizations or by contract
3. Program evaluators assigned to individual divisions
4. A program evaluation office as a staff function of the State mental health administrator
5. Program evaluation organizationally combined with other support services

No specifically designated program evaluators

The typical situation in years past was for the administrator and his various division directors to do their own program evaluation work as part of their overall responsibilities. The administrator was the principal evaluator who had the ultimate responsibility for performing his own evaluations.

This pattern usually led to very rudimentary kinds of evaluation, since virtually no clinical or business-oriented administrator had much technical training in mental health program evaluation. Another problem with giving the administrator sole responsibility for doing program evaluation was that other administrative activities were almost always more pressing than evaluation. Consequently, evaluation was lost in the shuffle.

Outside program evaluation by private organizations or by contract

Occasionally an outside evaluator may be called in to perform special studies, but seldom for ongoing program evaluation. It is especially appropriate for special cases in which the department's credibility is under question. An outside private organization, consulting firm, or a university may help provide an element of outside objectivity, but their biases are not necessarily fewer than the inside evaluator's, only different. Also, they may not feel free to recommend *no* changes at all and are likely to recommend only those changes the administrator is likely to accept.

This external orientation may lead to the evaluator's being viewed as an outsider who lacks the ultimate details of the program's past and special conditions. Also, because he is often thought of as a technical assistant, it is unlikely that an outside consultant will be considered part of the management team.

Another problem with an outside consultant is that he may not understand and share the philosophy and value base of the mental health agency administrator. As already noted, disagreement over philosophies underlying mental health programs can lead to destructive evaluations and bitter defensiveness within the agency. Since very few State mental health agencies have clearly articulated all their philosophies and objectives, the use of outside consultants for program evaluation is prone to such reactions.

The outside consultant is not likely to show initiative or be readily available to the managers within the agency. He is more likely to do the specific tasks or studies which he is assigned, send in the completed study as required by his contract's schedule, and leave it at that.

Program evaluators assigned to individual divisions (e.g., community services, mental hospitals, mental retardation, and business management)

Evaluation in each division would strengthen program evaluation relative to the divisions, but it would be less likely to serve the overall administrator managing the entire agency.

The individual evaluators would very likely be involved in program evaluation *studies* within their divisions rather than in facilitating program evaluation efforts throughout the State. There would be little likelihood of broad impact studies or cost-benefit studies coming from this kind of organization since no single evaluator would have responsibility for looking at issues that extend beyond his division. Therefore, this organizational alternative lacks flexibility.

A program evaluation office as a staff function of the State mental health administrator

Many States have organized staff support services (e.g., legal services, planning, staff development, and statistics) into various offices on the State mental health administrator's staff. Program evaluation would seem to fit naturally into that kind of structure.

The evaluator will need the strong and open support of the administrator. The evaluator should be part of the management team so that he is sensitive to management's needs and has the "insider" perspective. While the administrator must exercise some control over the evaluator to insure accountability and the utility of the evaluation results, he should give the evaluator as much autonomy as possible because the evaluator and his evaluation will be more credible if they can be seen as a relatively separate part of the system.[1]

A rule of thumb given for placement of program evaluation is ". . . place the responsibility for evaluation at a level appropriate to the decisions which the evaluation is to assist."[2] One of the best possible alternatives is to place the State office of evaluation directly under the State administrator of the mental health agency so that it serves as his right arm.

According to Franklin and Thrasher, in the mental health agency:

> the highest organizational level having responsibility and accountability for the direct delivery of services appears appropriate for special evaluation capabilities. Program evaluation would thus be available to all programs within the organization but the evaluation agency would not be accountable to program managers . . . It places evaluation close enough to service delivery and practicing professionals to permit in-depth knowledge of those events and conditions which have shaped programs, as well as familiarity with the current constraints and idiosyncratic factors impinging upon program managers. At the same time,

> the evaluation agency is sufficiently "distant" to be credible in all but a very few instances. This arrangement limits the need for 'imported external' evaluation to those rare instances in which the credibility of top management is itself suspect, or to those occasions requiring "one-shot" evaluation of such scope to necessitate, but not warrant, the considerable expansion of permanent evaluation personnel. By placing evaluation clearly within the structure of accountability and making the evaluator responsible to the top manager, evaluation as a management function is underscored and the administrative control of evaluation more clearly specified.[3]

An office of program evaluation would have an organizational relationship to all the other operating and support services and would be expected to serve them all. It could be perceived by the management team as an arm of the overall administrator just like the other support services.

Program evaluation organizationally combined with other support services

Relationships to Planning. At times, planning and program evaluation are put in the same office. This appears to be a workable arrangement as long as they are separate or parallel in the organization. They are definitely related functions. However, there appear to be problems in putting either one administratively under the other, since there are unique technical aspects of each and they are basically concerned with different aspects of the overall program—planning and operations. Historically, evaluation has often been buried when it was part of the planning office.

Relationships to Standards. Some States have established an office for setting and monitoring standards and linked this to program evaluation in an Office of Standards and Program Evaluation. These too are related functions and work well in parallel, but there may be disadvantages to subordinating either one of these to the other because there are clear differences in their activities. Standards may have definite sanctions (rewards or penalties) which are not appropriate for program evaluation. In addition, program evaluation has a much broader function throughout the agency than just standard setting and monitoring.

Relationship to Statistics. While the statistician at one time did most of the program evaluation that was done in State mental health agencies, the statistics office now is rarely linked organizationally with program evaluation. The statistics office provides services to most management functions, including program evaluation, and is usually seen as special staff to the agency administrator. The services which the statistics office provides may include the tabulation and analysis of statistical data and technical assistance in study design, data collec-

tion, and data processing. Typically, statisticians are rarely trained in either the mental health field or management principles. A close functional relationship should exist between program evaluation and statistics to assure that the statistical program is responsive to the evaluator's need for data. Ideally, the evaluator should contribute to the input of the statistics system and the design of its output reports. To facilitate the functional relationship, but not subordinate either office to the other, statistics and program evaluation could be located organizationally parallel to each other.

Relationship to the Management Information System. Here, too, there must be a close functional relationship, with program evaluation having ready access to information from the MIS. Very few States have tried to organizationally link program evaluation to the Management Information System (MIS). Generally, the MIS has technical functions of producing and processing data for various uses. Program evaluation makes use of information from many sources, including the MIS, in carrying out its managerial function.

Relationship to Research. A few States have placed research and evaluation in the same office. However, it seems best to keep these also in a separate or parallel relationship. Research concentrates on studies with experimental or quasi-experimental designs which may be inappropriate for program evaluation except in the small area of evaluative research (e.g., program research). If either office is placed in charge of the other, there may be considerable conflict over questions of pure and applied research and of who conducts needed research. Research does not ordinarily function as a tool of ongoing management, and researchers are seldom acquainted with the techniques of organizational analysis, budgeting and planning, operations research, or systems monitoring–skills useful to solving decision making problems and often possessed by program evaluators.

Staffing a Program Evaluation Office

To a considerable extent, the persons employed by a State mental health agency will vary depending on the activities and functions to be carried out by the program evaluators. At present most State level program evaluators are psychologists, statisticians, or sociologists (see Survey of Mental Health Program Evaluation, appendix I). The particular discipline is not the most critical factor in choosing a mental health program evaluator, however. More important are the specific skills and qualities of the individual. The *ideal* program evaluator would have knowledge of:

1. program evaluation technology;

2. demographic, social research, and some experimental research skills;
3. organizations and organizational behavior (especially human service organizations);
4. information usage and data management procedures;
5. public health and epidemiological concepts;
6. general systems theory and analysis;
7. the field of mental health (especially the mental health delivery system) and an appreciation of the clinical perspective; and
8. State government, public administration, and management.

The ideal candidate to be a program evaluator should also have the following personality traits and skills:

1. personal organizational ability (ability to organize his work, meet deadlines, work comfortably in an organized system);
2. ability to abstract and conceptualize;
3. ability to deal with those people who perceive evaluation as a threat;
4. willingness to involve others;
5. good listening skills and a desire to use them;
6. tact;
7. empathy;
8. ability to creatively identify workable alternatives based on analysis and interpretation of evaluation results.

Of course, since this is the ideal, very few candidates will have extensive knowledge and skills in all the above areas. Some of this knowledge can be acquired by working within the system, reading, or participating in short courses.

Selection of the candidate for any specific job will vary depending on the emphasis the administrator wishes to give to the position. If he wants mainly technical studies, he will choose the candidate with technical skills in research design and methodology. If he wishes to stress consultation and the development of evaluation throughout the department, he will choose the candidate with organizational ability and knowledge of mental health systems and State government. Similarly, an economist or accountant might be preferable if emphasis is to be on cost studies.

Not all of the program evaluation staff need hold Ph.D.'s or even master's degrees. A person with a bachelor's degree in social science or public administration may be just as capable at some aspects of evaluation. In special situations the evaluation office might even include nonprofessionals, volunteers, and representatives of consumer groups.

The size of the evaluation staff will depend on such factors as the

overall size of the agency/department, the functions and activities to be carried out, whether such activities as setting and monitoring standards are program evaluation activities or are separated into another unit, the stage of development of the overall agency/department, etc. In general, it would appear unlikely that a one-person evaluation office would have very much impact on the entire State program. In the Southern States, the average evaluation office consists of four evaluators and three clerical staff, but these are all new units which can be expected to expand as program evaluation becomes more sophisticated and as mental health programs are pressed for greater accountability.

Functional Relationships of Program Evaluation

Aside from the formal organizational aspects of program evaluation within the State mental health agency, there is still the issue of the functional relationships of program evaluation to the other units of the central office, to the operating agencies of the department, and to community mental health programs with which it must work.

Relationships to management

This document assumes that program evaluation is a part of management, that the administrator is the primary evaluator and that program evaluation helps in making decisions about programs and evaluations. (In a few places, program evaluation is perceived as strictly a support service that does technical studies on request and submits them in a fairly formal fashion to the administrators.)

- If program evaluation is really to be a management function, it would seem reasonable to include the program evaluator *on the management team*. The management team is the group of policymakers that includes the commissioner and his deputies, major division directors, and the major support unit directors, not the small executive group that meets almost daily. In most State agencies there is a team that meets once or twice a month to explore problems and formulate policy recommendations. Because ongoing program evaluation information is so vital to management activity, and because the debates at this level have such serious implications for what aspects of programs are to be evaluated, it would be desirable to have the evaluator sit on the management team even if he is not technically at this structural level in the organization.
- In addition, the program evaluator should have close functional relationships with the individual *operating division managers* so that he knows and understands their programs and evaluation needs. This

relationship should be sanctioned by the overall administrator, but actually initiated and maintained by the program evaluator, perhaps by scheduling regular meetings between himself and the division managers.

Relationships to data oriented support services

There is a special need for close working relationships and understandings between the various services of the central office that work with data—program evaluation, statistics, the management information system, planning, and research. The program evaluator should initiate contacts with these units and make special efforts to maintain good working relationships with all of them. One way to accomplish this might be to have a Data Use Committee, made up of the directors of these units, which meets monthly or biweekly to plan for better data use and to resolve problems. Such a committee might be sanctioned by the agency director. Informal contacts are always important in establishing working relationships and should be encouraged.

Relationships to program evaluators in field operations and local mental health programs

Much of the effectiveness of the State-level program evaluator will rest on the relationships he can establish with his counterpart evaluators in the field and local programs. Depending on the size of the State program, much can be done by personal visits, letters, and telephone calls. The evaluator in the central office should take the initiative in establishing these relationships and be sure that feedback is given to the field when some information or effort has been requested of the State office.

To further these relationships, a statewide Committee on Mental Health Program Evaluation that would include all interested mental health evaluators might be established. This committee might meet quarterly to explore common problems, exchange information, and collaborate on developing program evaluation designs, etc. The overall State director should probably provide such a committee with authority to meet, but the State program evaluation office would take the initiative in convening it, arranging meetings, getting out reports of meetings, etc.

Relationships to program administrators in the field or local programs

The State evaluation office must establish functional working relationships with local mental health program directors. This is particularly important since local programs often perceive the State program evaluation office as a threat. This is much less likely if the local administrators know the evaluator and what he is doing. The State pro-

gram evaluator might attend meetings of local administrators to explain his operation to them and to meet them personally. He should be sure to stop by the director's office whenever he visits their programs (and he may initiate visits to local programs). He should be sure that feedback on evaluation studies goes to the local administrators as well as to local program evaluators. As a matter of course, he should discuss any critical or controversial findings in studies of local programs with the local administrator *before* this information is reported to other managers.

Relationships to Federal and regional programs

The State office of evaluation must be familiar with Federal regulations and guidelines concerning program evaluation, standards setting, and monitoring. It should also be able to anticipate future Federal programs and requirements that might affect evaluation in its State. On a regional level, it might interact and exchange information through regional conferences, workshops, and collaboration. It might be useful for State program evaluators to take the initiative in forming regional associations on evaluation.

Footnotes

1. Franklin, Jack L., and Jean H. Thrasher. *Introduction to Program Evaluation.* Chapter 5. New York: Wiley-Interscience, a Division of John Wiley & Sons, forthcoming.
2. Wholey, J.S. et al. Proper Organizational Relationships. In *Evaluating Action Programs,* Carol H. Weiss, Boston: Allyn and Bacon, Inc., 1972. p. 119.
3. Franklin, Jack L., and Jean H. Thrasher. *Op cit.*

Chapter V

Relationships Between Management and Evaluation

Today, evaluation is a basic ingredient in systematic management and contributes to program planning, development, and operations. This chapter will discuss the relationships between administrators and evaluators.

Program monitoring is a service which evaluation can provide to the administrator. Regular monitoring alerts management to treatment/service trends and provides information indicating possible areas for program change. Evaluation also aids in the investigation and design of corrective actions to prevent crises and help identify and avoid possible negative side effects.

It is the position of this publication that program evaluation is part of the internal management process. Generally, it is an ongoing process carried out within the State mental health agency, but there may be times when an outside evaluation is appropriate. Program evaluation is a vital aspect of management. The all-important relationship between the administrator and the program evaluator is the pivotal point in determining whether evaluation is useful in decision-making and program management. In a creative and supportive relationship between the evaluator and administrator, the evaluator can produce brief and timely reports with the appropriate degree of technical content. In turn, the administrator can provide specific goals and objectives for the evaluator to work with, can encourage the evaluator to participate in all stages of a program, and can use his reports as part of the information involved in administrative decisions.

The Administrator's Use of Program Evaluation

Chapter II described the points at which the administrator makes greatest use of program evaluation:

1. *In program planning and development*
   a. Setting philosophies, objectives, and goals
   b. Setting criteria measures for outcome
   c. Setting standards and procedures
2. *In program management*

a. Monitoring progress—amount and quality
b. Identifying side effects—good and bad
c. Identifying problems—in direction, time, or costs
d. Responding to requests for studies related to crises

3. *In assessing program results*
   a. For outcomes and impact of programs
   b. For processes and procedures
   c. For satisfaction
   d. For reports to governors, legislatures, etc.

The administrator needs to build his credibility with regard to evaluation and its use. He can do this by openly supporting and initiating regular evaluations. By including the evaluator as part of the management team, the administrator can easily and willingly share evaluation information with other members of the team, and he can encourage and work closely and empathically with the evaluator in his job. If the program evaluator is on the management team, he can be called upon regularly for timely reports on the progress of various programs. His detection of problems, deviations, or side effects can then be used to the fullest and can be responded to by appropriate program modifications.

To participate effectively as a part of the management team of an agency, the program evaluator should be able to place his evaluation within the framework of the administrator's needs. In many ways the role of evaluation in management is a bit like that of the laboratory in the clinical practice of medicine. The physician needs accurate data from the laboratory studies, but there are many other factors that he uses in making a diagnosis and carrying out treatment. The most helpful laboratory report is one which not only gives accurate data, but also gives the physician additional observations on the case and provides some recommendations for the physician's use in evaluating his treatment. The laboratory will be unable to do this, however, if it is not made aware by the physician of any other clinical issues in the patient's case.

A great deal of the effectiveness of program evaluation will depend on the ways in which the administrator makes use of the program evaluator and his studies. The administrator must be personally involved with and sensitive to the evaluation process and make personal use of it. It is not sufficient to keep program evaluation at a third or fourth echelon level and to use the reports only occasionally in preparing publicity releases or sending in annual program reports to Federal agencies.

Overall, a great deal of the success of program evaluation will depend on whether the administrator uses program evaluation re-

ports to penalize deficiencies or to reward and encourage programs and to change procedures by reallocating resources. He should minimize the punitive uses because it is easy to demoralize people and make them defensive by constantly stressing the negatives. If the administrator does stress negatives in using evaluation, he puts the evaluator in the role of a policeman, which undermines the evaluator's effectiveness. Just as the administrator does not want to destroy his evaluator's effectiveness, so he should not subvert the evaluator's confidence in the administrator by ignoring, misusing, or distorting evaluation reports.

Occasionally the administrator will be faced with crises brought by outside criticisms, political charges, or unfavorable incidents. He might then call on the program evaluator to look into the matter and prepare a report to gain time and probably bring to light related information that can be helpful in managing the situation. This is not to imply that the evaluator will do a whitewash job, but he may be able to function as a buffer to a program under criticism. The evaluator must be able to respond quickly and forthrightly to gather the needed information and report it to the administrator in a timely fashion.

The administrator must be aware in documenting and evaluating programs for outside sources—the governor's office, the legislature, the press, citizens' associations, etc.—that there is always the possibility the reports can be given an unfavorable judgment by determined critics. This is a risk that must be taken by the administrator. It is not a reason to avoid program evaluation, for most often the manager who has a strong evaluation operation is better able to answer his critics and support his program, but he must be prepared for the time when a critic will turn the information against him. Often a critic is able to do this because the administrator has never explicitly stated his philosophies, and the critic approaches the same data from an opposing philosophy. (For example, reducing the hospital census without a concomitant statement of why this is philosophically desirable can be attacked by a critic who sees this same objective as threatening to the community.)

In closing this section on management use of program evaluation, two points need to be reemphasized. First, the mental health program administrator must be committed to using evaluation and encouraging accurate and timely evaluation reports about his program. Second, he would do well to include the program evaluator on the management team so that the evaluator can make relevant observations and recommendations as well as simply report the data. The administrator must ultimately make the decisions about programs on the basis of

many factors—programmatic, fiscal, political, and social—but he can receive real help from his program evaluator. The administrator needs an evaluator who goes beyond making cold, scientific appraisals to become empathetically involved. This means that the evaluator must be committed to participate actively on the overall management team and should be willing to make judgments and recommendations on the implications of his data. This dynamic role for the evaluator moves him beyond the more traditional emphasis on data gathering and analysis into innovative, participatory applications for management.

The Evaluator's Relationship with Management

In performing evaluative activities, the State level evaluator interacts with State level administrators as well as administrators on all levels. The working relationship that the evaluator has with each administrator will partly determine whether effective use is made of the evaluation results.

The program evaluator in a State mental health agency evaluation office will often function as a consultant to other units of the central office or to field operations as outlined in the chapter on f' .ctions. It is important that this consultant role be defined by the agency administrator, perhaps in an agency memo, so that the evaluator's activities are clear to all persons in the central office and in the field. Then people in the field will recognize his legitimacy as a consultant and will have a clearer notion of the help which the central office program evaluator can provide.

Periodically, the State level evaluator will inform the State administrator which local programs he has consulted with, the general nature of the consultation, and his recommendations for future consultation. It is the responsibility of the program evaluator to play this consultant role with initiative and energy. This requires responding promptly to requests for assistance, doing outreach consultations at field sites, and initiating consultation activities whenever it seems appropriate. Before beginning consultation, the State evaluator discusses the local program administrator's expectations with him and informs the administrator what State level evaluation can and cannot do for his program.

During consultation, the State evaluator helps local program personnel understand the benefits, capabilities, need for and the use of evaluation. He serves as an aide to State and local administrators when they are clarifying their programs' objectives and goals in relation to the overall State mental health program. Also, he can help

them develop a broader view of their programs' performances as compared to similar programs in the State or region. In these activities, the State evaluator acts as an *aide* and does not direct the activities unless specifically asked to do so. As the evaluator discusses the process of evaluation with an administrator and his staff, program personnel will develop an increased involvement with the evaluation process and greater discernment toward their program's operations. This helps prevent or reduce misunderstandings or feelings of hostility toward evaluation.

State evaluators, when they assist local programs in setting up monitoring and evaluation, and local evaluators doing the same for their own program, should recognize that individual programs as well as overall agencies vary in their stages of development and in their evaluation needs. At early stages in development of both agencies and programs, the need for evaluation is less in both amount and sophistication than at later stages. At first the need is for information about program progress and emerging problems, which tend to show up before the benefits in any program. The State level evaluator thus aids programs in planning studies that are timely and relevant to their stage of development.

Acting as an assistant to the administrator, the evaluator might also help set standards for the agency, to assure that those programs that must adhere to the standards have some input into the standard-setting process and to explain to administrators and staff what the standards entail and how the monitoring would take place. However, it is not recommended that evaluators do the actual monitoring of standards. Instead, a second office might better monitor the standards so that the same group is not both setting and monitoring standards.

The findings of the evaluation or monitoring should be reported to the administrator, perhaps in a form similar to the following:

1. Program *objectives*
2. Program *description*
3. Evaluation *results* (program strengths and weaknesses)
4. *Recommendations*

A program evaluator normally should discuss evaluation findings with the immediate local program administrator before he reports his findings to any higher level administrator. In addition to possibly finding significant factors that have been overlooked, it is good human relations to first discuss an evaluation with the program's immediate administrator.

The presentation of results should be in a short, concise style, avoiding jargon where possible. The report may use personal pronouns when appropriate and be as formal or informal as the occasion

requires. Usually, a one or two page summary is the most useful communication mechanism when it is keyed to a larger report. The statistics should be simple and for the most part descriptive. For example, percentages, pie charts, and histograms are helpful. Inductive statistics and complicated tables and charts may be useful if further questions are raised, but they tend to discourage people if placed in a report meant to be read by busy administrators. (The evaluator is not producing a scientific text for an exclusive audience of Ph.D.'s.)

Most importantly, the evaluator must include positive recommendations for the program. The evaluator should be cautious about stressing negative findings and producing only critical reports with no positive suggestions. He should avoid language and style that imply sarcasm or criticism of the programs or their personnel.

The program evaluator should be flexible enough to do brief and simple studies as well as sophisticated and scientific ones as the situation requires. He should have a high level of initiative and make recommendations for the overall program's management rather than simply being a reactive technician.[1] His style should be neither overly friendly nor coldly scientific and hypercritical.

The program evaluator should also make special efforts to insure that his reports are *timely*. This may mean reporting to the manager before the data are as thoroughly analyzed as the evaluator would like. However, the administrator must make decisions with deadlines and if the report comes to him too late, it is useless. In these situations it is better to have *some* information rather than *none* when the decision must be made.

One question concerns the presentation of evaluation data that compares different units (e.g., State mental hospitals, local community mental health centers) so that the units are displayed in competition with each other. While this type of reporting may lead to productive competition, stimulating those units that show up best to do even better, it may also discourage those that show up poorly and make them defensive. Perhaps such data should be displayed with the units identified only by codes unless there is already a spirit of cooperation.

The evaluator's reports may be used as background data to encourage fresh thinking from the staff for program improvement and to help establish priorities among program services in light of objectives and goals to make the best use of limited resources.

In presenting his evaluation report, the evaluator should be careful not to oversell his recommendations and should point out that evaluation is not a panacea but *only one* of many sources of information which an administrator will take into account in making a decision.

Privacy and confidentiality are additional issues with which the evaluator must be especially concerned. Just as an evaluator checks to see that a program has adequate safeguards protecting patient data, so he should be certain that all data he uses do not contain personal identification and that he protects his sources of information in order to avoid personal embarrassment and to build credibility with the staff.

Finally, to be effective, the evaluator must build and maintain credibility with the administrator. An open attitude and a willingness to initiate discussions on all stages of the evaluation process will increase the administrator's trust in his evaluator. The evaluator can make his evaluation report more believable by comprehensively examining all relevant factors in the evaluation; by acting consistently in all he does (e.g., internal congruency in the report, consistent work behavior); and by exhibiting an empathetic attitude toward the administrator and staff. In the administrator's eyes, the evaluator becomes more credible as he builds a track record of practical, reality-oriented evaluations that include specific findings and recommendations.

Footnote

1. Drucker, Peter F. How to make the presidency manageable. *Fortune,* November 1974, pp. 146-149 and 234-236.

APPENDIX I

Survey of Mental Health Program Evaluation in 14 Southern States

Introduction

In early 1974, a mental health program evaluation survey was mailed to nine State mental health agencies to obtain information about their present responsibilities, functions, relationships, organizational structures, resources, and staffing. The same information on program evaluation was gathered from the remaining five States by personal contact with those knowledgeable about evaluation in the States.

Whenever possible, both survey results and personal interviews were followed up and cross-checked for validity.

This report examines the responses of the 14-State region as a whole, and does not attempt either to summarize individual States or to draw any conclusions about a specific State. The description and analysis that follow serve as an information baseline about existing State-level evaluation activities. It will also aid in the production of alternative suggestions on how a State-level mental health program evaluation office might be staffed and organized and how the evaluation process may be used most effectively by/for management.

Structure and Functional Relationships

In the fall of 1974, the 14 Southern States varied widely in their organizational structures. Eight of the States [1] had grouped their mental health services into a larger agency (often named human resources) to provide more comprehensive and integrated human services delivery. Eleven of the States surveyed submitted organization charts that located the office which had the main responsibility for program evaluation in mental health.

The functional ties of the program evaluation office to other offices dealing with statistics, planning, fiscal administration, program administration, and staff development training could be grouped into three basic types of relationships.

The first type (Type I) was a structural relationship wherein the pro-

gram evaluation office was one and the same with, or part of, an overall office concerned with several of these functions.

The second type of structural relationship (Type II) included formal and informal collaborative associations (i.e., close, consultive, collateral, cooperative, and supportive) but did not have a direct administrative connection.

Type III included situations where there is no relationship, where no such office existed, or no survey answer was given. Many times when no answer was given, evidence elsewhere in the survey indicated there was no relationship (see table I).

Table I

Functional tie of the program evaluation office to five other offices, showing number of those offices under each type of relationship (14 Southern States)

Other offices	Type I (Same office)	Type II (Collaborative)*	Type III (None/NA)
Statistical office	5	6	3
Planning office	4	5	5
Fiscal administration	1	9	4
Program administration	4	6	4
Staff development or training	2	6	6

* Includes close, collateral, cooperative, consultive, and supportive relationships

Ten States said the program evaluation officer is a member of the management team. However, this person's position and duties varied widely. The descriptions ranged from low-level involvement:

> No special aspects, due to small size and just beginning.

or

> Team member, no special designation.

to a more intensive involvement indicated by statements like:

> Assist program managers in all phases of evaluation development, provide analytical support for data collected.

or

> Participates in all aspects of the organization from program development to budgeting.

to more formal statements such as:

> Member of department's executive committee.

or

Assistant commissioner.

Four States[3] said the evaluation officer was not part of the management team or they left the question blank.

Six States[4] reported they had or would have in the very near future a council, committee, or consortium of program evaluators fostering program evaluation in an agency-wide system. Six States[5] indicated there was a limited relationship between their program evaluation activities in mental health and other program evaluation units in the State government. When this relationship existed, it tended to be associated with mental retardation, vocational rehabilitation, the Department of Health Services, or a human resources management information system office.

Roles

Ten States from the 14-State Southern region indicated on the Mental Health Program Evaluation Survey that they conducted their own program evaluation studies within their agencies. The four remaining States[6] were not yet doing it but planned to, or left the question blank.

Seven States[7] reported that they played some role in the development of modules and mental health program standards for the operating parts of their agencies, but that they did not do the studies themselves. The other seven States were either not involved in developing these standards or were actively involved in monitoring them.

All States, with the exception of Mississippi, reported they offer consultation on program evaluation to the operating units of their agencies. However, only six States[8] offered program evaluation staff development consultation to these operating units.

With the exception of Arkansas and Mississippi, the 14 Southern States provided some form of liaison activity between State program evaluation and their universities and other governmental program evaluation activities. Nine of the States said they attempted to coordinate program evaluation activities within their agencies. Only five States[9] answered no or left this question blank.

Functions in Program Evaluation

The 14 States rated the degree of emphasis which the Mental Health Program Evaluation Office gives to 16 possible functions (see table II, p. 44). The highest priority functions were those which involve statistical needs (i.e., information systems and the monitoring

Table II

Summary of functions in program evaluation

	Survey question number	Activity description	Functions	Degree of emphasis		
				Very heavy or heavy	Slight or very slight	No answer, none or ?
I.	4	management information systems	statistical	7	4	3
	5	monitoring statistical data, routine reports, etc.	statistical	6	6	2
II.	7	site visiting	review	6	6	2
	2	setting standards	review	7	4	3
	1	setting program objectives and outcome measures	review	6	6	2
	3	monitoring standards	review	5	5	4
	6	assessment of needs for programs	planning/evaluative	5	7	2

Table II
Summary of functions in program evaluation—Con.

	Survey question number	Activity description	Functions	Degree of emphasis		
				Very heavy or heavy	Slight or very slight	No answer, none or?
III.	14	studies of continuity of care	evaluative	4	5	5
	11	cost analysis and cost effectiveness studies	evaluative	3	6	5
	9	outcome studies	evaluative	2	7	5
	12	peer review	review	3	4	7
	8	quality of life evaluation	evaluative	1	7	6
	10	client satisfaction studies	evaluative	2	6	6
	13	goal attainment scaling	evaluative	1	4	9
	15 & 16	special studies (give ex.) & other	.....	1	12	15

Note: Numbers in cells refer to responding States. Total N = 14 for each row, except for last row (includes two questions).

and reporting of statistical data). Review functions such as standards (setting and monitoring, and site visits) and the determination of program needs, objectives, and outcomes were second priority. Finally, evaluative studies of the impact and efficiency of program performance received the lowest priority.

This probably represents the state of development and concern for systematic data analysis. The most basic question is, "What's going on?" next comes "Is it a high quality program?" and only last is the question "How much is it accomplishing?" Since the State programs are in constant transition of personnel, organization, and program development, it is more likely that the highest concern will be at the basic level at almost any point. Furthermore, issues of quality and impact are harder to define and measure. It is thus not surprising that they have not yet been widely explored. We hope a project such as ours at SREB will provide some help to the States and to the program evaluators as they move into these newer areas.

Staffing

The surveys reported 54 staff members involved in State-level mental health evaluation for the 14 States. Individually, the States ranged from no staff members to nine staff members in the State operation with an average of four members per State. See table III for the professional background of these staff people.

Table III

Professional background of State-level program evaluators

Profession	Number	Percent
Psychologists	18	33.3
Statisticians (math)	9	16.7
Sociologists	8	14.8
Others*	8	14.8
Social workers	6	11.1
Accountants (business administration)	5	9.3
TOTAL	54	100

* The "Others" category includes: an engineer, vocational rehabilitation counselor, demographer, lawyer, educator, nurse, and two research assistants of unknown background.

The psychologists occupied three types of positions: (1) directors, (2) directors of research, and (3) research analysts or assistants. The statisticians tended to be technical personnel in statistical analysis and

data processing with only two working in administration. Most sociologists were listed as program evaluators or analysts. The social workers tended to be administrators while the accountants were auditors.

The professional background of the *directors* of this staff or the person who indicated main program evaluation responsibility in the States without established program evaluation offices included psychology, statistics, sociology, social work, and accounting (see table IV). The directors were almost all Ph.D.'s in their professional field, but there was no evidence that they selected more staff from within their own profession.[10] A total of 39 clerical positions were reported for the 14 States and the distribution ranges from 1 to 10 clerical positions, with an average of almost three clerical positions per State (see table IV).

Table IV

Professional background of State-level program evaluation directors

Director's profession	Number	Percent
Psychologist	7	50
Statistician	2	14.3
Sociologist	2	14.3
Social worker	3	21.4
Accountant (Business administration)	0	0
Others*	0	0
TOTAL	14	100

* Others, as defined in table III.

Budget

Eight States[11] reported their approximate annual budgets. The other six States reported no funds because no formal Program Evaluation Office existed, or simply failed to report any figures. Of the eight States that did report, the annual budgets ranged from $75,000 to $300,000 with a median of $135,000 and a mean of $159,000.[12] Only three States[13] reported any funds for contracted program evaluation studies.

Directors' salaries ranged from $12,000 to $28,000 with a median of $22,000 and a mean of $21,000. The salary average of all State mental health program evaluation staff (excluding clerical) was $15,200 and the median was $14,300.

Table V represents the salary ranges and averages for the program evaluators according to their profession.

Table V

Salary ranges for State-level program evaluators by profession

Evaluator's profession	Salary range	Median	Mean
Psychologist	$ 7,700-28,000	$21,000	$17,000
Statistician (Math)	10,000-25,000	10,000	12,900
Sociologist	10,300-25,000	15,500	16,400
Social Worker	10,300-26,000	17,000	16,900
Accountant (Business Administration)	8,000-18,000	10,700	11,800
Others*	8,500-21,000	12,200	13,100

* Others, as defined in table III.

Summary

In summary, the structural relationship between the program evaluation office and other offices in mental health was either direct administrative, collaborative or nonexistent. Direct relationships with other offices were generally with statistical, planning, and program administration offices. Collaborative relationships were mainly with the fiscal administration office. The office of staff development and training seemed to have the least contact with program evaluation activities.

Most State mental health programs were involved with direct evaluation work within their agencies and, in addition, they offered consultation on program evaluation to their operating units.

The emphasis on mental health program evaluation activities appeared to be first on descriptive data, then on quality review, and least on outcome and efficiency studies. Few States had any specific plans for enlarging or changing their program evaluation office.

The majority of program evaluation staff members were psychologists, as were program evaluation directors.

Conclusion

This survey of program evaluation within the State mental health agencies of the 14 Southern States provides a snapshot of what the status of activities, functions, staffing, and structure were in the fall of 1974. This will provide a baseline against which we can measure future developments in program evaluation within the States.

It also provides us with some clues regarding priority concerns and needs upon which the SREB staff can develop project activities to be most helpful to the States. Already this has provided the basis for planning workshops on "Setting and Monitoring Standards in the State Mental Health Agency" and "User Oriented State Level Information Systems." We expect to make considerable future use of this data in this project and in future program evaluation projects which we may undertake

Footnotes

1. Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, West Virginia.
2. Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, North Carolina, Virginia.
3. Alabama, Mississippi, North Carolina, West Virginia.
4. Arkansas, Florida, Kentucky, Maryland, Tennessee, Virginia.
5. Florida, Georgia, Kentucky, Louisiana, North Carolina, Virginia.
6. Alabama, Maryland, Mississippi, West Virginia.
7. Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, North Carolina.
8. Florida, Georgia, Kentucky, South Carolina, Tennessee, Virginia.
9. Alabama, Louisiana, Mississippi, South Carolina, West Virginia.
10. It was possible to examine the data for staff background bias by the director in hiring. There is no evidence that general bias in the States exists.
11. Alabama, Florida, Georgia, Kentucky, North Carolina, South Carolina, Tennessee, Texas.
12. *Median*—the middle value in a distribution of ordinal ranked values where 50 percent of the values are above and 50 percent of the values are below this middle value.

Mean—the arithmetic mean or commonly called "average" which is computed by adding up all the values and dividing by the number of values in the distribution.

The reason for reporting the mean and median is that the mean is sensitive to being skewed by extreme values. Also, the mean and median are the same value in a normal distribution. A quick judgment of skewness can be made by comparing these two averages.
13. Florida, North Carolina, Tennessee.

APPENDIX II

Supplemental References

(The following books contain useful information applicable to the evaluation process and its relationship to management)

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GLOSSARY*

Administrative Audit: a technique that describes and assesses the suitability of program policies and practices; a review of adherence of staff and program to designated standards and to effective patterns of work and division of responsibility.

Client Satisfaction Study: a study to assess the opinions, attitudes, and reactions clients express about the services they have received from a program. Clients of mental health programs may include families or referral agencies, as well as individual clients or agencies that received the direct services.

Cost Analysis Study: an analysis of how program expenditures are allocated among different items.

Cost-Benefit Analysis: a technique for assessing the relative effectiveness of alternative programs, strategies, etc. in terms of cost. It involves the calculating of a ratio of benefits (program achievements in monitoring terms) to the costs (financial costs of manpower and other resources) used in producing the program's achievements.

Cost-Effectiveness Analysis: a variation of cost-benefit analysis which attempts to specify and evaluate social costs and benefits of different programs and services that have the same target population and identical predefined goals.

Evaluative Research: utilization of scientific research methods and techniques for the purpose of determining evaluation methods. Evaluative research gives special attention to issues of validity and reliability without necessarily having experimental controls.

Goal: a reality-constrained, time-specific, problem-oriented statement of an achievement which an organization seeks to bring about. (Example: to educate all Portage County residents arrested for driving while under the influence of alcohol.) Sometimes used interchangeably with objective or defined as the broad value-based purpose of a program (see Objective).

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* This is not intended to be an exhaustive list of terms, but a reference for the key terms used in this publication. Many of them were adapted from: *Definition of Terms in Mental Health, Alcohol Abuse, Drug Abuse, and Mental Retardation,* National Institute of Mental Health, Mental Health Statistics, Series C No. 8, 1973.

Impact Study: an analysis of the relationship of program outcomes and activities to the original need and to any related consequences. (Related consequences may be economic, social, political, or clinical.) Impact studies may be prospective or retrospective (see Outcome Studies).

Management Information System (MIS): a network of component data parts designed to automatically take certain management actions and to provide a flow of key information to decision-makers for other managerial actions. It is composed of procedures, equipment, information, and people who process and use the information. Some parts of such a system are designed so that actions are taken automatically according to pre-established procedures (e.g., supplies are automatically ordered when the inventory falls below a certain level), while other information is systematically processed and forwarded to decision-makers. Management Information Systems often use computers for much of their work, but computers are not necessary in order to have an MIS.

Needs Assessment: a study to determine the needs of a target population in a particular problem area and the existing patterns being used by the population to meet those needs (see Utilization Review).

Objective: a concise description of a desired end state sought at a specified future time, related to a human need. (Example: reduce alcohol-related motor vehicle deaths 20 percent by 1978.) This term has also been applied to subgoals of a program, as in Management by Objectives (see Goal).

Outcome Study: an analysis of the results or effects of program services. These include side effects as well as the intended outcomes (planned goals).

Peer Review: a mechanism for evaluation of both treatment and rehabilitation procedures by a formal review of clinical records by a team of peers. This is most commonly applied to physician review of medical care and treatment procedures, but it is not necessarily restricted to medical review.

Professional Standards Review Organization (PSRO): an organization of physicians established under Federal law and regulations to provide peer review of diagnostic and treatment services in a local area. At present this organization reviews medical services provided under federally supported programs, but is expected to expand to services for other third party payment plans.

Program Evaluation: the process of determining the results of programs and analyzing the extent to which they have accomplished their predetermined goals and objectives.

Program Monitoring: a continuous assessment of a program's activities, progress, resources, and the demands made upon it to detect deviations from program goals, plans, or procedures. Public service programs are especially likely to experience changes in any aspect of their operations and need a procedure such as this in order to correct for these changes.

Quality of Life Standards: standards which relate to the human dimensions of client experiences while receiving services (most often used with respect to inpatient services). These include attention to such aspects as privacy, dignity, and the physical and psychosocial environment.

Reliability: the condition in which repeated observations of the same phenomenon with the same instrument yield similar results.

Standard: a state or condition accepted as a minimal or exemplary condition, appearing in law, regulation, or policy.

Utilization Review: a process of monitoring and evaluating the appropriateness and duration of use of a program's services. Currently it is most often applied to hospitalization for mental disorders or physical disorders to insure that persons are not hospitalized unnecessarily, or kept in the hospital beyond what have been judged to be appropriate time periods for various diagnostic or treatment conditions.

Validity: the extent to which criteria do, in fact, measure what they are designed to measure.

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