THE NIMH APPROACH TO EVALUATING THE COMMUNITY MENTAL HEALTH CENTERS PROGRAM

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COMMUNITY mental health centers have probably stimulated more interest and excitement than any other mental health program in history. The volume of journal articles and books, the new training programs, and the rhetoric of the day all testify to the program's major impact upon the mental health scene. As of July 1972, 493 community mental health centers had staffing or construction grants from the National Institute of Mental Health, Health Services and Mental Health Administration, and of these 325 are in operation. When all these funded centers begin providing services, they will serve areas inhabited by more than 68 million people. These centers are located in every State, the District of Columbia, Puerto Rico, and Guam, and they cover areas ranging from the inner city to rural farmlands—about 35 percent of all the rural counties in the United States are within the catchment areas of the community mental health centers already funded.

As increasing numbers of community mental health centers have come into operation, they have been serving larger numbers of people. In 1968, about 275,000 people were served at community mental health centers; this number increased to more than 370,000 in 1969 and to approximately 500,000 in 1970. Obviously, other operating statistics have increased apace—number of staff employed, total expenditures, volume of indirect services, and the like.

The program's impressive growth has been accompanied by major conceptual shifts in the delivery of mental health services. While much less tangible than the centers themselves, these concepts may, in the long run, have a far more profound influence. The impact of such ideas as community based services, continuity of care, comprehensiveness, and outreach have extended far beyond the community mental health centers themselves.

The scope of the program, the complexity of its basic concepts, and the costs involved all mandate that informed judgments be made concerning the effectiveness of community mental health centers. To help make such judgments, the NIMH has developed an evaluation approach which recognizes that evaluation must serve a number of direct and indirect functions and takes into account the Institute's wide range of responsibilities as a public agency. The approach also recognizes that evaluation of this program is closely related to other program activities and incorporates the development of new methods, the collation of past findings, the development of evaluation resources, and new investigations. While the evaluation approach will continue to evolve with the Community Mental Health Centers Program, major parts of the evaluation process

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have already been implemented, and several studies have been completed. These developments have taken place notwithstanding the limited resources available.

The NIMH evaluation approach consists of the coordination of four major components—monitoring, enhancing the evaluation capability of community mental health centers, program description, and evaluation of the national program.

Monitoring

As a public agency, NIMH is responsible for insuring that its grantees are expending their funds appropriately. The monitoring process provides information which helps the Institute assess the extent to which community mental health centers are complying with the legislation under which they were funded, the Institute's regulations, and the terms of the grant award. The monitoring process is carried out through site visits, applications for continuation support, and an annual inventory.

Site visits. Community mental health centers are visited after they have been in operation for at least 90 days and annually thereafter during the term of the grant. The site visits are conducted by regional office staff together with personnel from State and local mental health departments. Outside consultants also participate in the visits whenever appropriate. The primary objective of site visits is determination of basic compliance with NIMH requirements. When centers are found in violation, they are so notified and advised that continuation of grant support will be contingent upon rectifying the deficiencies. In addition, the visits give the inspection team an opportunity to consult with the staff of the center concerning other improvements in their programs. While subjective in format and broad in scope, the site visits have been an important source of information about the operation of community mental health centers. Some of the information which becomes available through these visits has been described by Ozarin and co-workers (*1*).

Annual inventory. Each year all operating centers are required to submit a report describing their activities during the year in quantitative terms. These reports provide extensive information on revenue, expenditures, direct and indirect services, staff activities, referral sources, and much more. They permit a detailed analysis of each center as well as inter-center comparisons. To increase the usefulness of these reports for monitoring, we at NIMH are developing a system that will identify centers which are unusual or those outside specified levels on a series of indices, such as cost per episode of care or percent of staff hours devoted to day care.

Continuation applications. Centers are required to submit an application for continuation of their staffing grants every year. These applications provide information on staffing, finances, and program for the current grant year, as well as a projection for the year for which continuation support is requested. The application includes an itemized statement of receipts and expenditures, a listing of all staff with their salaries, descriptions of program achievements both past and projected, and an assessment of the impact of the center upon its community.

Enhancing Evaluation Capability

By and large, community mental health centers have been ill equipped to develop evaluation programs of their own. In all of the communities served, the need for community mental health services greatly exceeds their availability, and centers have directed their resources to meeting these needs. Even when some funds to hire staff have become available, staff members with expertise in evaluation have been in short supply. Despite these handicaps, a number of centers have moved ahead with their own evaluation programs, and some have done so quite successfully.

The Institute's interest in helping centers increase their evaluation capabilities has several facets. It is of obvious value to help the staffs of the centers study the local impact of their services so that they can make better decisions about the allocation of their scarce resources. In addition, a national evaluation effort is dependent upon accurate data from the operating centers. Without such data, national evaluation cannot succeed.

NIMH has used three primary mechanisms to promote the self-evaluation capability of community mental health centers—grants for staff positions for research and evaluation, support of methodological studies, and the dissemination of information about the evaluation of programs.

Grants for staff positions. Research and evaluation is a service eligible for support under the Community Mental Health Centers Act. Of 132 centers reporting on their operations for a sample week in 1970, 67 indicated that some staff time was being spent on research and evaluation. However, this activity makes up only a small

proportion of total staff time. Of the total hours worked by staff in the sample week, 2.6 percent was devoted to research and evaluation. Because this is not a service which is revenue producing, it is likely to suffer disproportionately as the Federal share of staffing grants declines.

Methodological studies. Through grants and contracts, NIMH is supporting a number of studies to improve the evaluation capabilities of centers. Research currently in process includes the following examples.

1. A major effort is underway to develop utilization review procedures for community mental health centers (*2*). In addition to facilitating the requirement of the national program that services be appropriate to the needs of those being served, utilization review is frequently a requirement for reimbursement from third-party payers. It is likely to become even more important with the advent of some form of comprehensive health insurance. Effective utilization review can help assure high quality care at reasonable costs.

2. The wide variation in the objectives of mental health services for different types of clients has made the evaluation of direct services quite difficult, since no standard instrument can be applied to all clients and all programs. A goal attainment scaling procedure which attempts to apply a standardizing process to each case has been developed and is currently being tested (*3*).

3. Difficult as it is to evaluate the effectiveness of direct services, it is even more difficult to assess the effect of indirect services. Since consultation and education is one of the five essential services, research has been supported to develop a methodology for evaluating one type of indirect service —program consultation to schools (*4*).

4. To help centers better assess the costs of their services, the NIMH has supported efforts to develop an adequate accounting system for centers (*5*) and a cost-finding manual (*6*).

5. In order to disseminate information about evaluation and to stimulate interaction between centers, several conferences on evaluation have been held in various parts of the country. These range from primarily informational and inspirational sessions at meetings of the National Council of Community Mental Health Centers in Philadelphia in September 1970 and Detroit in April 1972, to a detailed and critical consideration of methodological and practical problems by evaluation specialists at a 3-day forum on program evaluation in Brainerd, Minn., in October 1971.

In addition, several publications relevant to evaluation have been issued, including a description of existing data systems that selected centers have developed (*7*), and manuals and annotated bibliographies on research in program evaluation (*8*) and on the use of research in planning creative change (*9–11*).

Program Description

The success of any evaluation process is closely linked to the degree of clarity with which the program under study can be described. Particularly in a program of such broad range and complexity as community mental health centers, the development of statistical data and descriptive studies is very important. For example, case studies of operating community mental health centers can be helpful to those administrators interested in examining their own agency's program.

Statistical data descriptive of individual centers and of the national program serve a similar purpose. In essence, program description, the third component of the NIMH approach to evaluation, is an important mechanism to enhance learning from the experience of others. And the overall statistical characteristics of the program, such as numbers and types of persons served, are the raw material from which evaluative judgments of achievements can be made. NIMH uses two major procedures for program description—an annual inventory and special studies of particular activities in individual centers.

Annual inventory. Referred to earlier as a monitoring device, the inventory is also an important vehicle for program description. It provides statistical data on such characteristics as the age, sex, and diagnosis of all persons using community mental health centers, average lengths of stay, staffing patterns, revenue and expenditures, sources of patient referral, and analysis of indirect services (*12–15*).

Special descriptive studies. These special studies have been designed to highlight particular aspects of the Community Mental Health Centers Program with emphasis upon issues of highest priority. The case approach has been used as the basic format within an analytic framework. Studies already completed and published have covered such subjects as staffing patterns and staff utilization (*16*), partial hospitalization (*17*), rehabilitation services (*18*), inpatient services (*19*), and community mental health services for children (*20*).

Evaluation of the National Program

The fourth component in our approach to evaluating the centers is the one most directly focused on providing evaluations on the extent to which and conditions under which the entire program is achieving its goals. Using funds as authorized by the 90th Congress in amendments to the Community Mental Health Centers Act, specific evaluative studies are supported by contract. Most of these studies are designed to provide a basis for improvement by determining the extent to which and conditions under which the various goals of the program are being achieved.

As one integral part of the National Institute of Mental Health's mission in research, training, and services, the Community Mental Health Centers Program is an instrument of national mental health policy. As such, its goals must be supportive and consonant with those of the national mental health mission. In this sense, the goals of this program are intermediate or process goals to further the Institute's end or outcome goals. These overall NIMH goals can be stated as follows:

1. Reduce the incidence of mental disorders.
2. Increase the rate of recovery from mental disorders.
3. Reduce the level of disability associated with chronic mental disorders.
4. Increase community understanding, acceptance, and support of mental health programs.
5. Raise the level of mental health and improve the quality of community life.

The major process goals of the Community Mental Health Centers Program, with examples of contract evaluation studies completed, in process, or planned to determine the progress toward these goals, are described in the following section.

Improve the organization and delivery of community mental health services through the development of a coordinated system.

In essence, this goal recognizes the fragmentation and lack of coordination of the traditional mental health services in this country. As Feldman and Goldstein have pointed out, "To provide a broad range of services, it has often been necessary to rely on a number of unrelated agencies, each with its own special requirements. Under such conditions, a flexible, ongoing treatment approach geared to a patient's changing needs is not likely" (*21*).

To help further this goal, more than 85 percent of all community mental health centers have been funded in two or more existing facilities that have come together to form a coordinated program. A community mental health center is, therefore, much more accurately described as a combination of services rather than as a single place. This attempt to develop a system of care is a major experiment in interorganizational relationships and one that has important implications for the delivery of all human services.

However, bringing different organizations together under a Federal grant does not insure well-integrated services. To determine the extent to which coordination and continuity of care are being achieved, as well as to highlight some of the major problems, several studies are in process or have been completed.

1. The development of a method to measure continuity of care (*22, 23*).
2. A study of nine multi-affiliate community mental health centers to evaluate the impact of various administrative arrangements on coordination and effective interorganizational relationships. The nine areas studied contained a total of 68 different mental health facilities, and 64 of these were affiliated with the community mental health centers (*24*).
3. A statistical and case study of nine centers to assess the nature and extent of the relationships between community mental health centers and other caregivers and the correlation of close relationships to achieving the centers' service goals (*25*).
4. A study, still underway, to evaluate the integration of mental health services with other human services.

Increase the accessibility of mental health services to all in need.

The Community Mental Health Centers Program must remove the economic, geographic, and psychological barriers which too frequently have prevented people from using badly needed mental health services. The catchment area approach, the decentralization of services into storefronts and other community outposts, and the requirement that services be provided without regard to ability to pay are among the mechanisms used to enhance accessibility. This objective is designed to reverse the all-too-frequent situation in this country in which people with the greatest need for mental health services have had the greatest difficulty finding them.

A contract study is in process to help determine the extent to which a sample of community mental health centers has increased accessibility and the conditions under which this has occurred. In this study, surveys were made of the attitudes of the general population of the catchment areas, as well as of center staff and personnel in schools, police and courts, welfare, and medical services.

Increase the quantity and range of available community mental health services.

A major goal of the Community Mental Health Centers Program is obviously to increase sharply the supply of community mental health services until nationwide coverage is achieved. Kentucky, with 98.7 percent of its population covered, leads the States in this regard.

Most information about the amount of services provided comes from the annual inventory of community mental health centers discussed earlier. In addition, the Institute has funded a study to evaluate the extent and the conditions under which the initiation of community mental health centers has affected the availability and quality of mental health services in four counties which were also studied a decade ago (*26*).

Another study has been initiated to determine the impact of the poverty amendments of the Community Mental Health Centers Act that provide a higher proportion of Federal funds to qualifying centers.

Enhance the responsiveness of mental health services to community and individual needs.

Community mental health centers must be relevant to the needs and problems of the people they are intended to serve rather than the needs of the providers. The image of the "high quality" mental health service providing long-term individual psychoanalysis to a selected few patients while a community abounds with drug problems, school dropouts, and other concerns is anathema to the thrust of the Community Mental Health Centers Program. Mechanisms such as community involvement in the planning and operation of center programs, the use of new careerists, and the development of methodologies to assess community needs for mental health services are all designed to enhance responsiveness.

To improve the capability of community mental health centers to assess need, a study is in process to develop a system to obtain and analyze demographic profiles of the catchment areas served by the centers (*27*). These profiles will provide basic information to help identify the extent and nature of the needs for mental health services. When the profiles are linked with data on the types of persons served by centers, utilization rates for various population subgroups can be calculated. The utilization review protocol currently under development for community mental health centers (*2*) will help to assess the relationship between patient needs at a particular point in time and the type of service being provided. Two studies have recently been initiated on the catchment area concept as applied in particular centers.

Provide a single high quality standard of community care.

Community mental health centers are required to provide services of the type and amount needed without regard to ability to pay. In common with other health and human services, mental health has, in the past, too frequently served poor people less adequately than those who can pay. Unfortunately, "services for the poor have very quickly become poor services" (*28*).

A study is currently in process which will help evaluate the equity with which people of all socioeconomic levels are being served by community mental health centers. The study will attempt to assess the extent to which people from different ethnic and socioeconomic groups are being served, the amounts and types of service provided, and the relative levels of satisfaction of the groups with the services they received.

Decrease the utilization of State mental hospitals.

The major impetus for the enactment of the community health centers legislation in 1963 was the development of community services as an alternative to State mental hospitals which, in many parts of the country, were the only mental health resources available. Avoiding the unnecessary use of State mental hospitals is a value basic to the entire Community Mental Health Centers Program. It is manifested by the establishment of centers to prevent unnecessary entry into the hospitals and to reduce the length of stay for patients already in residence.

Studies are underway in a number of catchment areas to assess the impact of community mental health centers on the utilization of State hospitals. One study will use data from a county psychiatric case register to help clarify the relative utilization of centers and State hospitals. Another study will

analyze and develop a typology of the relationships between community mental health centers and State mental hospitals. It will identify the political, administrative, and fiscal factors associated with each type of relationship and the implications of these for the mental health services available to persons with varying needs. In addition, the annual inventory of community mental health centers provides such data as the number of former State hospital patients seen in centers and the number of persons referred from centers to State hospitals.

Increase the participation and support of State and local groups in the Community Mental Health Centers Program.

Federal grants for the construction and staffing of community mental health centers must be matched by other resources. In the grants for staff positions, for example, Federal participation begins at 75 percent of the staffing costs, declines to 30 percent, and terminates at the end of 8 years. Obviously, the development of alternative sources of support for community services is an important objective of the program, and one without which it could not survive. In good measure, adequate financial support is a function of community interest and participation. Without sustained public support at all levels, a major mental health program cannot be successfully implemented.

Two studies have been done on types and amounts of citizen participation in centers, both using a case study approach (*29, 30*). Another study examined sources of funds of community mental health centers and the impact of the declining levels of Federal support on the funding patterns and services (*31*). Similar information related to viability of programs is expected from the previously mentioned study of centers funded under the poverty amendments. Supporting these studies are data from the annual inventory of community mental health centers which indicate, for example, that the contributions of State and local governments to the centers now exceed that of the Federal Government.

Future Directions

Funds to evaluate the Community Mental Health Centers Program first became available in fiscal year 1969 and, therefore, the great majority of studies have but recently been completed or are still in process. As they are completed, the next phase of the evaluation process has begun—dissemination of the results and an analysis of the studies to determine their implications for changing the program. The reports of all studies, as submitted by the contractors, are being made available through the U.S. Department of Commerce Documentation Center.

In order to analyze the implications of these reports for program change, we have established a policy analysis group consisting of NIMH staff members from various branches. This group is to determine both (*a*) desirability and feasibility of the recommendations in each report in light of other program priorities and resources beyond the scope of the individual studies and (*b*) what broader program implications can be developed from considering the cumulation of completed evaluation studies, NIMH staff studies, current program development activities, and the feasibility of implementing various changes in this program.

As the Community Mental Health Centers Program evolves, our overall plan for evaluation must evolve as well. Three likely directions for such evolution are to increase citizen participation in evaluation (*20*), to link monitoring procedures with quality standards and accreditation procedures (*32*), and to include studies linking application of the centers program concepts of how to deliver services to outcomes for clients and community. In addition to devising new studies directed both toward the concepts of community mental health and the operations of community mental health centers, the resources invested in each aspect of the four-part evaluation approach must be reconsidered, along with reconsideration of the approach itself. A static, inflexible evaluation process is not likely to meet the needs of a flexible, dynamic program.

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