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CHAPTER 3

EVALUATION ON A SHOESTRING: A SUGGESTED METHODOLOGY FOR THE EVALUATION OF COMMUNITY MENTAL HEALTH SERVICES WITHOUT BUDGETARY AND STAFFING SUPPORT

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As they move beyond the stage of adolescent infatuation, previously ardent suitors are now taking a closer look at their "new love," the community mental health service delivery system. New demands, including responsiveness to the icon of accountability, are now being placed upon this "love" which once had been accepted easily and without question.

In responding to this demand for accountability, some community mental health directors and administrators have been able to rely on the recent development of sophisticated computer-based evaluation systems which have been adapted for use in the community mental health service delivery system. However, utilizing these systems effectively results in many economic and programmatic demands which only a few existing community mental health centers and other mental health service delivery oriented agencies can meet.

The inability of a majority of community mental health program directors and administrators to utilize these complex computer-based evaluation systems does not negate, however, the importance of "evaluation." Rather, it places them in the midst of a profound dilemma—how do they meet the demand for accountability without adequate budgetary and staffing resources? Some have responded to this question by ignoring it, while others have attempted to rapidly develop strategies which have not been soundly thought out.

Evaluation has been defined as "the development of information relating to treatment programs that is useful for policy decisions" (Fox and Rappaport 1972). The purpose of this paper is to suggest a methodology for the evaluation of community mental health services, when specific budgetary and staffing support is lacking that will provide information which will meet the standards set by this definition.

Following a discussion of those problems which have been and will be encountered in the development of these kinds of evaluation strategies, specific examples will be given related to the evaluation of direct services and indirect services as well as to the performance of cost-benefit analyses.

Underlying Issues and Problems

The development of innovative strategies for the evaluation of community mental health programs in the absence of budetary and staffing support can only go forward after underlying issues and problems are recognized, faced, and resolved.

Making a Commitment To Undertake Evaluation

Most community mental health program directors have received their training primarily in the *clinical* aspects of mental health services delivery. As a corollary, few have received specific or adequate preparation for the various tasks inherent in administration, including evaluation. Nevertheless, it is this same program director who has had neither training nor previous exposure to administration and evaluation—upon whom the burden for performing such tasks falls when the community mental health program does not have separate budgetary and staffing support for evaluation.

This situation can provide either a challenge or a threat. Unfortunately, the tendency to view it as a threat has been the more pervasive response. Documentation for this conclusion is provided through a review of the literature. The majority of articles written in recent years on the subject of evaluation in community mental health service delivery programs have been prepared by individuals whose interests and expertise are in the area of clinical research. Very few articles have been written by individuals whose primary responsibilities encompass community mental health program administration.

When this observation is more closely examined, several factors can be viewed as playing an important causative role in the development of this situation. Foremost among them, and perhaps the most obvious, has been the above-mentioned lack of

training in this area which most community mental health program directors and administrators have had. However, this lack of training is a relatively easy situation to correct, particularly when more and more training programs in this area are appearing each day and are available to interested community mental health program directors and administrators. The persistence of the problem despite this increasing availability of training programs suggests that other causative factors may be at work which must be examined more closely.

In this regard, attention has already been given to the position in which the director finds himself if his program evaluation turns out to be negative (Murphy 1971). This possibility places the director in a "double bind." A failure to conduct evaluation will be seen as an abrogation of his responsibility toward the demand for accountability. On the other hand, if he follows through on this responsibility, he runs the risk of losing his position if the evaluation is negative. Therefore, it is understandable if many community mental health program directors and administrators try to avoid this double bind by busying themselves with other responsibilities, of which there are many, hoping that the problem of evaluation will go away.

Second, some directors and administrators, who are essentially clinicians both by training and by orientation, will resent allocating a significant portion of their attention to the preparation and analysis of data, a nonclinical activity. These "clinical" program directors may have a tendency to view evaluation as a nonprofessional task, and this may lead to the rejection of evaluation as being beneath the clinician turned program director or administrator. If possible, he would like to turn this task over to another individual. Finding no one available, the matter is dropped.

Third, it must be recognized that many of the clinical staff upon whom he will depend for the collection of data often have an equally biased attitude against evaluation, which dovetails with his own negativistic attitude. The community mental health program director who is not willing to stand up against staff resistance cannot carry out effective evaluation. The easiest way to avoid a potential conflict with staff is to lower the priority for evaluation.

The solution to these conflicts is not easy, readily available, nor tangible. The only possible solution is transcendental. The community mental health program director or administrator must take the great leap forward by making a *commitment* to the importance of evaluation which will enable him to transcend and overcome any of the considerations described. It is further recognized that, if he is unwilling to recognize these underlying issues and to make this commitment, it is likely that no effective evaluation will occur in that community mental health program.

Medical Records

Even if the community mental health program director is able to transcend the problems described and to make a commitment to the development of effective methodologies for evaluation in the absence of adequate budgetary and staffing support, he still faces realistic problems including the gathering of a data base.

To solve this problem, he must once again set aside his bias as a clinician and recognize that the purpose of medical records is not only to tell a story through the clinical record, but also to provide a data base which will yield identifiable information which can then be handled statistically.

Some program directors may see these two requirements as in conflict. Many staff members with their own clinical orientation may also be resistive to completing medical records in a manner that meets these two requirements.

Consequently, it becomes the responsibility of the program director to review the medical record-keeping system being utilized in his mental health service delivery system and to be sure that it provides both an adequate statistical base for the evaluation protocol as well as an adequate descriptive base of the case being treated. Later illustrations will indicate specific aspects of the medical records system which can be useful in these evaluation strategies.

Continuity of Care

A community mental health service delivery system, on behalf of a single client, can often involve not only numerous services within a single agency, but also the services of numerous agencies within a single system. The ability to track an individual client through the various services of a specific agency or through the various agencies within the system becomes a paramount consideration in the development of adequate evaluation strategies.

Without adequate budgetary and staffing support which allows the development of a centralized and computerized data system within the mental health service delivery system, tracking becomes a difficult task. A possible resolution of this problem lies in the development of cooperative working relationships not only between the members of the various treatment teams within a community mental health service agency, but also between the various directors and administrators of the multiple agencies in

the community that participate in the total service delivery system. If this cooperation is attainable and, furthermore, if it is recognized that this cooperation may have potential benefits to all agencies concerned, then certain noncomputerized and more simple strategies can be introduced which will effectively, but within limits, create the potential for tracking patients through the system.

Staff Resistance

As indicated previously, the resistance of clinical staff to the collection of data necessary for the implementation of evaluation strategies will be a significant factor. However, it must be also recognized that, although the involvement of clinical staff is important in the development of the data base necessary to pursue these evaluation strategies, it is not necessarily the sole resource available to the innovative program director.

Most community mental health programs have a support staff, consisting primarily of secretaries, whose responsibilities and talent in the areas of the collection of data and evaluation often go unrecognized and unutilized. Consequently, a possible route to overcoming staff resistance may be found through the placement of a significant responsibility for collection of data in the evaluation process upon individual members of the staff other than clinical personnel. This "end-around" may not eliminate staff resistance but will certainly enable the program director to lessen it.

Continuous vs. Episodic Monitoring

The availability of and publicity given to complex computer-based evaluation systems have led to the creation of a myth which, if accepted by the community mental health program director or administrator, will certainly undermine his ability to do effective evaluation even in the absence of adequate budgetary and staffing support and in the presence of his personal commitment.

Computer-based evaluation systems generate an information overload which is of great interest to individuals with specific background and expertise in evaluation, but which also is often overwhelming to those without specialized training or interest in the field. Furthermore, the evaluation can be carried out only if an overwhelming amount of data is generated which can be analyzed and re-analyzed in multiple ways.

However, it is important that the program director who is faced with the problem of developing innovative evaluation strategies in the absence of adequate budgetary and staffing support recognize that, in order to conduct effective evaluation, he may not require continuous information input. Rather, he should be aware that there are many areas, some of which will be illustrated later, which do not need to be evaluated continuously in order to provide the information which is of maximum usefulness to him. The adaptation of an "episodic" system in which several evaluation strategies are employed at different times may yield an adequate evaluation program for him without either creating information overload or leading him to feel that there is too much to be done too quickly in too short a time.

Selection of Areas To Be Evaluated

The impact of the availability of computer-based evaluation systems has also helped to create another myth which has been detrimental to the development of interest in the community mental health program director in initiating evaluation strategies without budgetary and staffing support. This myth is that effective evaluation requires the availability of information about everything. Not only is this far from the truth, but it also tends to negate the importance of the evaluator, namely the community mental health program director or administrator, in selecting the areas to be evaluated.

An objective overview of the program by the evaluator, with the assistance of staff and an advisory board, can lead to the identification of specific areas which are more relevant to the policy-making and planning activities of that specific community mental health program system than others and, therefore, require priority evaluation. While it is true that a computer will analyze all information supplied to it, it does not necessarily follow that the information which is provided is of equally critical importance to the community mental health program system which will benefit from the results. Consequently, the creative program director or administrator can play an important role in designating which areas require evaluation and which do not.

Summary

In this section, six primary underlying issues and problems have been identified and described which the community mental health program director or administrator who is attempting to implement adequate evaluation strategies without adequate budgetary or staffing support should recognize. The problems associated with making a personal commitment, medical records, continuity of care, staff resistance, the development of a monitoring plan and the selection of areas to be evaluated must be considered prior to the implementation of any specific strategy for the evaluation of direct services and indirect services or the performance of cost

analyses. A failure to confront these issues and to achieve a satisfactory resolution will greatly undermine the director's ability to devise a successful methodology.

Historical Description of Program

Prior to a description of the evaluation methodology and strategies which have been utilized in each of the above areas, it is important that a brief description of the community mental health service system in which they were employed be given.

The Southern Arizona Mental Health Center in Tucson, Arizona, was established in 1962 as an outpatient branch of the Arizona State Hospital, located in Phoenix. Created intially to function as a followup clinic for patients discharged from the Arizona State Hopsital, it broadened its approach over the years by developing more programs that reached out to the community. Nevertheless, because the Southern Arizona Mental Health Center did not have an inpatient facility and because the responsibility for commitment belonged to the Pima County Hospital, it became rapidly apparent that a complete community mental health service system was lacking.

Consequently, in late 1968, a task force was formed by the Pima County Health Department including representatives from the center, the Arizona State Hospital, and the Department of Psychiatry at the newly formed University of Arizona College of Medicine. From these discussions, a tightly organized agreement was signed by the three groups that resulted in the pooling of services and the placing of services within a unified community mental health service network. Thus the Combined Mental Health Care Program was designed to provide all the services of a comprehensive community mental health center including emergency services; inpatient services through short-term inpatient hospitalization at the local level and long-term inpatient hospitalization at the State level; partial hospital services including day care and halfway house services; outpatient services, both adult and child; and consultation and education services.

This community mental health service system is headed by a coordinator who functions as chief of psychiatry at the Pima County Hospital and director of the Southern Arizona Mental Health Center. A conference committee consisting of representatives of the three signers of the agreement as well as a community advisory board, acting in both policy-making and advisory capacities for this community mental health service system, was organized (Beigel, Bower, and Levenson 1973).

Evaluation of Direct Services

In the context of the specific underlying issues and problems outlined in the first part of this paper and the historical description of the program which followed, attention will now be turned to those strategies which can be successfully utilized in the evaluation of direct services delivered by a community mental health service system.

Attention will be focused upon those service areas which have specific reference to the problems of client utilization, progress, and outcome. They have been selected for evaluation because of their specific ability to provide "information . . . that is useful for policy decisions" (Beigel et al. 1973). Consequently, the discussion will focus on how the information obtained was useful in program policy analysis and decision making.

Sources of Referral and Disposition

The community mental health service system should be conceived as part of the total "human service" delivery network. Therefore, it becomes important for a community mental health service system to analyze and follow the input into its system as defined through the clients who seek help and the places from which they are referred. Although this analysis can include an evaluation of the demographic characteristics of the clients, attention will be given in this discussion to the sources of referral of clients because of the importance of these data in program policy and decision making.

Table 1 illustrates the referral pattern both into and out of the comprehensive emergency services network which is available 24 hours a day, 7 days a week. As will be noted from table 1, these services are available during the day, Monday through Friday 8:00 a.m. - 4:00 p.m., at the main community mental health center facility, the Southern Arizona Mental Health Center, and 24 hours a day at the emergency room of the Pima County Hospital where the short-term inpatient services are also located.

Prior to the implementation of the Combined Mental Health Care Program in 1970, the lack of coordination between the Pima County Hospital and the Southern Arizona Mental Health Center resulted in a nonexistent emergency services system in which the overwhelming majority of patients (79 percent in 1969) presented in crisis situations between the hours of 4:00 p.m. and 8:00 a.m. The program protocol of the Combined Mental Health Care Program called for the development of a preventative strategy which would encourage clients to come for help not only in an emergency situation, but

Table [1].—Walk-in clinic (screening and evaluation) March 1973

Southern Arizona Mental Health Center			*Pima County Hospital*		
Monday-Friday (8:00 a.m. - 4:00 p.m.)			(24-hours a day)		
New patients seen	147		Total patients seen	317	
Total patients seen	237				
Total visits	402				
NEW PATIENTS: SOURCE OF REFERRAL					
		Percent			
Self	33	22	Monday-Friday (8:00 a.m. - 4:00 p.m.)	39	
Pima County Hospital emergency room	13	9			
Friends or relatives	44	30	Monday-Friday (4:00 p.m. - 12:00 p.m.)	167	
Other health agencies or physicians	28	19			
Other mental health agencies	8	6	Monday-Friday (12:00 p.m. - 8:00 a.m.) Saturday-Sunday	111	
Other community agencies	10	7			
Law enforcement and courts	11	7			
			Dispositions: Total	317	
NEW PATIENTS: DISPOSITIONS					
		Percent			*Percent*
No referral	29	20	Pima County NP	73	23
Pima County NP Unit	6	5	SAMHC Walk-in Clinic	51	16
SAMHC outpatient programs	44	30	Rest of SAMHC	5	2
SAMHC day program	3	2	No referral needed or requested	137	43
Tucson South	7	5	Other agencies	17	5
Tucson East	10	7	Pima County Medical Service	8	3
Still being seen in Walk-In	37	25	Pima County Drug & Alcohol Program	26	8
Other agencies	11	7			
Failed to return	0	-			

also to come earlier on a walk-in basis during normal day-time working hours (Beigel 1971).

The data in table 1 is therefore useful in analyzing the impact of this strategy. During the month used as an example, 464 patients were seen for initial evaluation either at the Southern Arizona Mental Health Center or the Pima County Hospital. The data furthermore reveals that 186 (40 percent) were seen during the 40 hours a week (24 percent of total available time during the week) between the hours of 8:00 a.m. and 4:00 p.m. Monday through Friday. This is more than twice the percentage of those who appeared for these services during these hours prior to the program.

These data would therefore suggest to planners that the strategy of implementing a walk-in clinic with a full treatment team which is available to handle problems during day-time hours has been successful in diverting a significant number of people from waiting to seek help until the evening or night-time hours when emergency cases tend to concentrate. Continuing with an analysis of the data presented in table 1, several other aspects deserve further comment.

Fifty-two percent of the patients seen in the walk-in clinic at the Southern Arizona Mental Health Center during its open hours (8:00 a.m.-4:00 p.m.) were either self-referred or sent in by friends and relatives. This measure can be viewed as an indirect indicator of the program's visibility within the community. Following this statistic will enable the program director or administrator to be aware of changes in this visiblity. Furthermore, when individuals present themselves without having been referred from another health or community professional or agency, it might suggest a greater degree of community acceptance of mental illness with individuals more willing to come for help earlier and prior to the development of an acute crisis.

The relatively few patients seen in the emergency room of Pima County Hospital during day-time hours, Monday through Friday, in comparison to the number of new patients seen at the walk-in clinic of the Southern Arizona Mental Health Center (approximately 4 miles apart) offers an indication of the relative success of the program in being able to attain its own identification apart from the hospital. The creation of this identification is critical to the success of a community mental health program since one of its established goals is to provide accessibility and to encourage individuals to come for help prior to their perceiving their situation as being so bad that they must go to a hospital.

A breakdown of the other sources of referral to the walk-in clinic also provides an aid to the

program director or administrator in assessing the relationships of his program to other care-giving sources. Any significant decrease in the percentage over an extended period of time might suggest that a particular problem, perhaps a lack of visibility or an interagency conflict, may be present in that area. However, a spontaneous increase in referrals from a specific part of the care-giving system might suggest a need for further consultation to determine the reason for it.

With regard to dispositions, these data can also be useful in helping the community mental health program director or administrator plan program policy and implement decision making. For example, one of the stated purposes of the walk-in clinic is to act as a crisis intervention clinic as well as a resource for screening and evaluation for further treatment. The percentage of people for whom no referral is made can therefore be an indication of the effectiveness of the crisis intervention strategy. As shown in table 1, 20 percent of the patients seen in the walk-in clinic did not require a further referral. Furthermore, it is anticipated that a significant percentage of the 25 percent who were still being seen in the walk-in clinic at the end of the month (probably 20 percent of those) will also not require a further referral after one or more visits. Significant shifts, either downward or upward, in the percentage of patients who do not require any further referral will be of importance to the program director in assessing the ability of the walk-in clinic team in maintaining the crisis intervention orientation.

Since the walk-in clinic is open only 8 hours a day, 5 days a week, and the rest of the emergency services are delivered at the Pima County Hospital, continuity of care between the two organizations is critical to the successful creation of an emergency service delivery system. These data provide a measure for assessing the effectiveness of continuity of care. As noted in table 1, 51 patients were referred during the month from the Pima County Hospital emergency room to the walk-in clinic of the Southern Arizona Mental Health Center, but only 13 appeared for further evaluation (26 percent). The availability of these data suggested to the program director a need to look into the continuity of care mechanisms between the two programs.

Upon investigation, it was discovered that the possible reasons for the low followup percentage by patients referred from the emergency room to the walk-in clinic were that those patients who lived within the immediate vicinity of the Pima County Hospital were less likely to follow up after being referred to the walk-in clinic 4 miles distance, and that those patients referred to the walk-in clinic during night-time hours (midnight to 8:00 a.m.) were also less likely to follow up.

This suggested to the director a need to more adequately utilize for some emergency room patients those mental health services offered by the more closely contiguous community mental health center in Pima County (Tucson South). Consequently, instructions were forwarded to the emergency room of the Pima County Hospital that, despite the Combined Mental Health Care Program agreement, referral of patients seen in the Pima County Hospital emergency room should be made more on a geographic basis.

Followup after the implementation of this order revealed a marked increase in not only the percentage of successful referrals to the Southern Arizona Mental Health Center (58 percent 2 months later), but also the number of successful followups to other community mental health programs in Pima County. In addition, these data also suggested the need for a better tracking of patients. This led to the development of a tracking slip which is now completed in triplicate in the emergency room with one copy being given to the patient, one being retained for the hospital files, and the last copy being forwarded to the walk-in clinic. This not only provided a more accurate assessment of the number of people who were following through after referrals from the emergency room, but also enabled the walk-in clinic to have a mechanism which enabled it to do followup on those patients who did not appear for evaluation.

In summary, this small area of data collection has been chosen to illustrate how even seemingly insignificant and easy-to-collect data can have a specific impact on policy and decision making. In considering the budgetary and staffing support required to mount this particular aspect of the evaluation system, it should be pointed out that all data described are collected by secretaries at the time the patient presents himself or herself at the walk-in clinic or, alternatively, is kept by the worker who sees patients in the emergency room. These data are recorded in a log which is forwarded to the director at the end of the month. The amount of man-hours involved in the completion of this task, yielding the data discussed above and shown in table 1, is approximately 4 hours per month.

Analysis of Services Delivered

The analysis of services delivered by a community mental health service system is extremely important to the implementation of policy and program. Effective analysis depends on the availability of a data collection system which yields information

about the types of services delivered and the individuals who are providing them.

In the service system which does not have access to a computer-based data gathering network, the availability of clerical staff is of considerable importance. Figure 1 illustrates the "ticket" which is used by the Southern Arizona Mental Health Center to collect the data described above. This ticket is completed by the secretary of each service unit from her own observations and after information from the therapist has been received. This information serves as the base for an analysis on the types of therapeutic intervention performed by the staff members as well as the base for an analysis of staff utilization in the delivery of those services. The availability of this information is particularly important for cost analysis studies.

As an illustration of the utilization of these data, consider the importance of a comparison between the group services provided by a mental health service system and individual services. Although the choice of service provided should be based on the needs of the patient, it should be recognized that the actual delivery of services may depend upon the clinician's own area of expertise. The availability of these data will enable the program director or administrator to analyze whether there is sufficient balance within the staff to provide for both group and individual services.

In a community mental health service system where the ratio of group to individual services provided is low, important questions should be raised: (1) Is the deficiency in group services due to the lack of adequately trained and experienced staff? (2) Is the deficiency in group services due to the bias of the staff currently employed? (3) Is the deficiency of group services due to a lack of adequate facilities? None of these questions, however, can be answered unless the program director has access to data which will alert him to a problem which he must proceed to answer.

Another example illustrates the utility of data in relation to delivered services. Most community mental health program staffs consist of individuals from a variety of professional and nonprofessional backgrounds. An appropriate balancing of these individuals is not only important to an effective interchange of ideas, but also to the achievement of the program's fiscal integrity. The availability of these data will enable the program director to assess the quantity and types of services being delivered by representatives of each professional and nonprofessional discipline and to know whether role differentiation or lack of it is playing any significant role in service delivery.

These data are also available to the innovative program director at a relatively low cost. The use of a ticket such as the one illustrated in figure 1 makes available to the program director all of the information which is required to answer the questions raised above. The completion of this ticket can be a primary responsibility of a secretary and the collection and recording of the data can be the responsibility of a receptionist who will have time available during the day. Allowing her to set aside a certain portion of her day, which at the Southern Arizona Mental Health Center amounts to approximately ½ hour each day, to gather this data is a low-cost mechanism for the retrieval of information of utmost importance.

OUTPATIENT SERVICE TICKET
(PLEASE TYPE ALL INFORMATION)

TREATMENT CENTER CODE_____

DATE_____

NAME_____ HOSPITAL NO._____

TYPE OF CONTACT

- ☐ D. DAY CARE
- ☐ 1. BRIEF INDIVIDUAL INTERVIEW (LESS THAN 30 MINUTES)
- ☐ E. INDIVIDUAL INTERVIEW (MORE THAN 30 MINUTES)
- ☐ 3. GROUP THERAPY
- ☐ 2. PRESCRIPTION FOR MEDICATION ONLY (NO OTHER SERVICE)
- ☐ 6. FAMILY THERAPY
- ☐ 8. COLLATERAL INTERVIEW
- ☐ 4. INITIAL OUTPATIENT CONTACT
- ☐ 5. PSYCHOLOGICAL TESTING
- ☐ 7. EDUCATIONAL SESSION
- ☐ A. VOCATIONAL REHABILITATION
- ☐ F. PHYSICAL THERAPY
- ☐ B. OTHER REHAB. SERVICE
- ☐ H. TELEPHONE CONTACT (15 MIN OR MORE)
- ☐ V. PROLIXIN INJECTION
- ☐ 9. OTHER TYPE

PRESCRIPTION GIVEN: 1. ☐ YES 2. ☐ NO

STAFF DISCIPLINE

- ☐ 1. PSYCHIATRIST
- ☐ 2. PHYSICIAN (NON-PSYCHIATRIST)
- ☐ 4. PSYCHOLOGIST
- ☐ 3. SOCIAL WORKER
- ☐ 5. TEACHER
- ☐ 7. NURSE
- ☐ B. VOCATIONAL REHAB. WKR.
- ☐ E. PHYSICAL THERAPIST
- ☐ C. OTHER REHAB. WKR.
- ☐ D. PSYCHOLOGY ASST. (SAMHC ONLY)
- ☐ 8. MENTAL HEALTH SERIES
- ☐ 9. OTHER (SPECIFY BELOW)

OFF GROUNDS

- C. ☐ HOME VISIT
- G. ☐ PROTECTED GROUP LIVING SITUATION

ARIZONA STATE HOSPITAL

DP-14-SA (REV. 7/73)

Fig. 1. A simple form for recording outpatient service contacts.

Table 2.--Pima County psychiatric inpatient service March 1973

Total Patients Admitted 73

SEX:		RESIDENCE:	
Male	38	Tucson South	23
Female	35	Tucson East	11
		Tucson North	35
		Arizona	2
		Out of State	2

ADMISSION STATUS:		FEE:	
Voluntary	55	Full pay	14
Petition	18	Part pay	10
		No pay	49

REFERRED FROM:		*Percent*
Pima County Hospital emergency room	33	45
SAMHC Walk-in Clinic	15	21
SAMHC OPD	3	4
SAMHC Day Program	0	-
SAMHC Halfway House Program	1	1
Juvenile Court	1	1
Nursing homes	1	1
Jails	5	7
Pima County Hospital - Medical	3	4
Other hospitals	2	3
Tucson South	1	1
Other mental health agencies	2	3
Police officers	5	7
Tucson East Mental Health Center	0	-
Private physicians	1	1

AVERAGE LENGTH OF STAY: 5.3 days

72

DISPOSITIONS:		*Percent*
Arizona State Hospital	4	6
Other hospitals	3	4
SAMHC Walk-in Clinic	3	4
SAMHC OPD	10	14
SAMHC Alcoholism Program	1	1
SAMHC Day Program	2	3
SAMHC halfway houses	2	3
Arizona Medical Center	2	3
Palo Verde Hospital	4	6
St. Mary's Hospital	3	4
Private physicians	2	3
Pima County OPD	0	-
Pima County medical service	2	3
Nursing homes	4	6
Pima County Jail	6	8
Other mental health agencies	12	17
Tucson South	4	6
Tucson East	0	-
Juvenile Court	0	-
A.M.A.	3	4
No followup	5	7
Death	0	-

The Analysis of Hospitalization Data

Since one of the underlying principles of community mental health services delivery is the accessibility and availability of mental health services at the local level, good program planning and implementation require that the program director or administrator has available information that provides data regarding the success or lack of success of the short-term hospitalization program. Table 2 illustrates various aspects of the collection of data related to the inpatient service in this comprehensive mental health service system and offers further examples of how the analysis of service data is valuable to the innovative mental health program director.

Prior to the availability of the walk-in clinic, most of the admissions to the Pima County Hospital Neuropsychiatric (NP) Unit were female (60 percent). Crisis intervention strategies tend to be more successful with the female who frequently presents an acute situational anxiety or depressive reaction in the context of a personality disorder. When the walk-in clinic system was inaugurated, a marked shift was noted in the ratio of female to male admissions to the NP unit with male admissions now being greater than female admissions each month. This example illustrates how a minute piece of data can be valuable to a program director in assessing the impact and effectiveness of a portion of the community mental health service delivery system.

Although the Pima County Hospital NP Unit serves the entire county, there are other inpatient services within the community associated with the Tucson South and Tucson East catchment areas which also have federally funded community mental health centers. Consequently, as illustrated in table 2, the percentage of admissions to the NP Unit from the Tucson North catchment area, which does not have a community mental health center inpatient service, is always higher than from the other catchment areas. Any significant change in this ratio would imply to the community mental health program director a need to examine the integrity of the mental health service delivery system.

Although the laws of the State of Arizona provide for the emergency detention, by petition, for mental health evaluation of individuals who seem

dangerous to themselves or others, the voluntary admissions to all treatment units, including the Pima County Hospital NP Unit, are predominant. However, occasionally an increase in the number of patients being admitted on emergency detention or petition orders is noted. The availability of the data collection system illustrated in table 2 enables the mental health center director to monitor the ratio of involuntary to voluntary inpatient admissions and to be immediately aware of any problem that exists in this area within the total community mental health service system.

While admissions to the Arizona State Hospital during this month constituted only 6 percent of all dispositions from the inpatient service, it is important to note that *37 percent* of the patients discharged were referred to other 24-hour care settings including other hospitals, nursing homes, and the jail. Not only does this statistical summary provide a mechanism for monitoring the success of the community mental health service system in providing locally based hospitalization for patients who require 24-hour care, but it also gives the program director an opportunity to analyze utilization of these referral facilities at the point of discharge from Pima County Hospital.

Similarly, an analysis of the sources of referral to the Pima County NP Unit continues to provide documentation of the importance of early intervention. As shown in table 1, only 5 percent of those patients seen at the walk-in clinic required disposition to the Pima County Hospital NP Unit. In contrast, 45 percent of all admissions to the NP unit came from its emergency room. This suggests that an individual who goes to the walk-in clinic during day-time hours has less likelihood of requiring admission to the hospital than an individual who is seen in the emergency room of the Pima County Hospital during the evening or night-time hours. This finding will help to provide the program director who is seeking justification for the importance of a walk-in clinic and an emergency services intervention program with objective supporting data.

These are a few illustrations of how analysis of data to show the overall utilization of available hospital services can be important to the community mental health program director or administrator. It is equally significant to note that all data presented in table 2 are gathered and collected by the ward clerk on the psychiatric unit as part of her normal duties and do not require the participation of any clinical staff. This reduces the possibility of staff resistance and maintains the low cost of evaluation for the program which does not have adequate budgetary and staffing support.

Followup Evaluation

The importance of followup and outcome evaluation studies for any community mental health service system has been well described. However, it is equally clear that the service system which faces the problem of evaluation, particularly of followup and outcome studies, without adequate budgetary and staffing support is encountering a very difficult problem.

Without adequate budgetary and staffing resources, an objective assessment of outcome is an almost impossible task. However, subjective analysis is not impossible and should be implemented even if objective analysis of outcome is not possible.

Outcome evaluation implies an assessment of the progress that the patient has made as a result of the treatment which he has entered. Often, it is not possible to assess the progress he has made until the treatment has been completed, since the dependency engendered by the treatment relationship is often a factor which influences the outcome. Consequently, any community mental health service system which is interested in completing outcome evaluation studies should focus on that period of time following the discharge of the patient from treatment.

With limited budgetary and staffing support, a community mental health service system should recognize the possible importance of volunteers in performing outcome evaluation. An active volunteer service program, functioning as a part of the total service system, can assume the principal responsibility for conducting a subjective analysis of patient progress. A trained volunteer can make a competent subjective assessment of the patient's current state at the time that he makes a home visit or telephone call to the patient after discharge. This subjective analysis not only can provide evaluation data but also can have important ramifications for the patient, since it provides a continuous contact which is not dependent on the patient's initiating it.

An important aspect of outcome evaluation, which is often ignored, occurs at the time that the patient may return to treatment. Many individuals seen in the community mental health service system have been patients in the past, both within that system and others. Consequently, an important part of outcome evaluation is an assessment of the progress or lack of it which the patient has made since discharge at the time that he returns for further treatment. Consequently, it is important to emphasize to clinical personnel the importance of gathering an adequate intake history not only of the problems that precipitated the patient's return to treatment, but also how the patient has functioned

since being discharged from treatment. This latter part of the clinical record then becomes a clinical resource for the evaluation of outcome.

It is in this area that the resistance of staff and other personnel to evaluation studies is most likely to be encountered. The importance of the strategies described above lies partially in that they will help to reduce this resistance by making the evaluation a part of ongoing clinical care. Although it certainly can be suggested that this will bias the data, the person who will probably do the followup and outcome evaluation is unlikely to be the same person who was involved in the treatment. These conditions will help to objectify the data which are being collected.

In this subjective evaluation methodology, follow-up and outcome studies offer an opportunity for episodic rather than continuous monitoring. For program policy planning, continuous monitoring is not necessary if care is taken in the selective *randomization* of those who will be followed up in the manner described.

Finally, in conducting followup and outcome evaluation studies, attention should be paid to other aspects of the "life system" in which the former patient operates including his family. Consequently, a rather brief questionnaire given to the family and completed at the time that the followup is done by the volunteer can be an important and useful control against the subjective bias which may be introduced by the evaluator or the former client.

Although none of the strategies which have been suggested are purely objective and, furthermore, although none pertain to actual symptom analysis, they can be valuable to the innovative community mental health program director by providing him with feedback. The utilization of volunteers as well as the intake worker when a former patient has returned for further treatment does not represent any additional cost to the community mental health center program and therefore reduces the cost of limited followup and outcome evaluation strategies to a minimum.

Evaluation of Indirect Services

The provision of direct services by community mental health service systems constitutes only a portion of the total services provided. The innovative community mental health program director or administrator must develop a methodology for the evaluation of indirect services and include it within the overall evaluation program. A limitation of evaluation to an analysis of direct services would be mistaken since the large amount of time which is spent by the staff on the three major components of indirect services—responding to *telephone requests for information*, engaging in *therapeutic contacts* via the telephone with clients and their families, and participating in various types of *consultations* to other community human service agencies—will have gone unrecognized.

Telephone Requests for Information

Although the principal physical point of entry for most individuals into the community mental health system is through the intake center, the walk-in clinic, the majority have come after having first initiated either directly or through other members of their family a request for information about available services. In many situations, furthermore, this request for information cannot be responded to by a secretary because it is accompanied by a therapeutic question. At these moments, the staff becomes involved and can utilize a significant portion of its time in responding to these telephone requests for information.

Although an accurate assessment of the actual amount of time spent in answering these telephone requests is too cumbersome a task for the staff to accept, the staff can keep a log of the number of these telephone requests to which it responds. Figure 2 illustrates the log which is used at the Southern Arizona Mental Health Center for recording not only telephone requests for information but also the number of therapeutic telephone contacts, as well as community consultation contacts.

Therapeutic Telephone Contacts

The therapeutic telephone contact is defined as any *direct* contact with a client, a member of his family or a close friend which has been undertaken, via the telephone, to explore or discuss some aspects of the patient's treatment or a particular problem which he is encountering at a time when he or the therapist is not available for direct therapeutic intervention.

The concept of a therapeutic telephone contact is consistent with the basic theory of community mental health center service delivery since it enhances the accessibility and availability of the client to the system and its caregivers. It is therefore important for the program director to pay close attention to the amount of time which staff is spending in this endeavor.

As with telephone requests, it is often a difficult task for the director to make an accurate assessment of the amount of time spent by staff members in this activity. As in the first instance, part of the difficulty is related to staff resistance. However, once again, using the log illustrated in figure 2, the community mental health center administrator or

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CONSULTATION CONTACTS

NAME: MONTH:

DATE	TR*	TTC**	CC***	DATE	TR*	TTC**	CC***
1				17			
2				18			
3				19			
4				20			
5				21			
6				22			
7				23			
8				24			
9				25			
10				26			
11				27			
12				28			
13				30			
14				31			
15							
16							

* - TELEPHONE REQUEST ** - THERAPEUTIC TELEPHONE CONTACT *** - COMMUNITY CONSULTATION (In-Person Contact)

Fig. 2. A simple log for recording the number of telephone and community consultation contacts.

director will be able to gather general information regarding the therapeutic telephone contacts engaged in by staff members.

Community Consultation Contacts

Finally, it is important for the community mental health caregiver to be involved in activities which relate to other aspects of the human service delivery system. These are carried out consistent with the principles of prevention associated with the community mental health service concept. Consequently, it is once again important for the center program director or administrator to have an adequate assessment of the extent of activities and the number of people reached by staff through these "community consultations."

Assessing the quantitative aspects of these indirect service areas is critical to the community mental health program director or administrator because they may help to reflect and anticipate changes in the direct services which are being delivered by the service system. For example, increased community consultation contact with a specific portion of the human services system may generate either an increase or a decrease in referrals to the walk-in clinic depending on the goals of that contact.

Cost Analysis

In response to the demand for accountability, the community mental health program director or administrator will also have to develop strategies for the performance of cost analysis of these programs. These data can provide a very useful measure of the impact of the program beyond the evaluation of the actual direct and indirect services which it delivers.

Two strategies will be described which can be utilized in program planning and analysis by the innovative program director or administrator and do not require specialized budgetary or staffing support.

Table 3.—Cost analysis and "fair share" calculation for Pima County residents: June 1970

Treatment modality	Daily charge per patient (June 1970)	Pima County census at Arizona State Hospital (ASH)	Total daily cost
Adult psychiatry	$15.46	132	$2,043.72
Physically infirm	26.41	5	132.05
Geriatrics	16.75	26	435.50
Mental retardation	15.76	36	567.36
Child psychiatry	30.61	6	183.66
Maximum security	18.97	10	189.20
Total		215	$3,551.49
			X 365
Annual cost of Pima County residents at ASH			$1,296,294
Southern Arizona Mental Health Center budget			+ 551,000
Total expenditures for Pima County			$1,847,294
Pima County "fair share" of total ASH 1969-70 budget[1]			-1,406,342
"Deficit" from "fair share"			$ 440,952

1. Twenty and three-tenths (20.3) percent of $6,927,795.

Impact of Community Mental Health Services on State Hospitalization Costs

In creating the Southern Arizona Mental Health Center in 1962, the Arizona State Hospital had hoped to justify the additional expenditure for staff and personnel in Tucson by decreasing the the rate of State hospitalization from Pima County (Beigel, Bower, and Levenson 1973). This decrease did not occur, and the creation of the Combined Mental Health Care Program was partially intended to produce fiscal results that would justify the continued existence and future expansion of the Southern Arizona Mental Health Center. Therefore, a method for performing a cost analysis was worked out based on a "fair share" of the Arizona State Hospital budget for Pima County, computed on the basis of population, with Pima County being entitled to 20.3 percent, since this is the percentage of people in the State residing within Pima County.

Tables 3-5 illustrate the impact of the Combined Mental Health Care Program on the expenditures for the care of patients from Pima County at the Southern Arizona Mental Health Center and the Arizona State Hospital. Prior to the initiation of the Combined Mental Health Care Program, as noted in table 3, the programs for Pima County residents at the Southern Arizona Mental Health Center and the

Table 4.—Cost analysis and "fair share" calculation for Pima County residents: March 1971

Treatment modality	Daily charge per patient (March 1971)	Pima County census at Arizona State Hospital (ASH)	Total daily cost
Adult psychiatry	$16.54	75	$1,240.50
Physically infirm	31.40	6	188.40
Geriatrics	18.74	20	374.80
Mental retardation	17.49	30	524.70
Child psychiatry	38.40	6	230.40
Maximum security	27.50	12	330.00
Early discharge	30.59	1	30.59
"Flamenco II" program	16.54	10	165.40
Total		160	$3,084.79
			X 365
Annual cost of Pima County residents at ASH			$1,125,948
Southern Arizona Mental Health Center budget			+ 637,582
Total expenditures for Pima County			$1,763,530
Pima County "fair share" of total ASH 1970-71 budget[1]			-1,737,802
"Deficit" from "fair share"			$ 25,728

1. Twenty and three-tenths (20.3) percent of $8,560,605.

Table 5.— Cost analysis and "fair share" calculation for Pima County residents: December 1971

Treatment modality	*Daily charge per patient (December 1971)*	*Pima County census at Arizona State Hospital (ASH)*	*Total daily cost*
Adult psychiatry	$24.80	34	$ 868.00
Physically infirm	39.11	4	156.44
Geriatrics	22.11	16	353.76
Mental retardation	21.93	31	679.83
Child psychiatry	51.84	3	155.52
Maximum security	29.71	13	386.23
Social learning	37.50	3	112.50
"Kachina II" program	24.80	7	173.60
Total		124	$2,885.88
			X 365
Annual cost of Pima County residents at ASH			$1,053,346
Southern Arizona Mental Health Center budget			+ 763,970
Total expenditures for Pima County			$1,817,316
Pima County "fair share" of total ASH 1971-72 budget[1]			-1,925,850
"Surplus" over "fair share"			$ 108,534

1. Twenty and three-tenths (20.3) percent of $9,486,946.

Arizona State Hospital were operating at an annual deficit from the fair share of $440,952. In other words, the combined cost of caring for patients from Pima County at the Arizona State Hospital and the Southern Arizona Mental Health Center was $440,952 more than the amount allotted for Pima County ($1,406,342) as determined through a computation of the fair share of the total Arizona State Hospital budget.

By March 1971, 6 months after the initiation of the Combined Mental Health Care Program, this deficit had been reduced to $25,728 (table 4). By December 1971, 16 months after the initiation of the Combined Mental Health Care Program, a surplus of $108,534 (table 5) had been generated.

The importance of this type of cost-analysis evaluation on the part of community mental health service systems cannot be underestimated. The examples which have been given were extremely critical to the programs of the Southern Arizona Mental Health Center since the surplus which was accumulated enabled the center to expand its community-based program. For example, as a direct result of the availability of these data, the Southern Arizona Mental Health Center was able to approach the legislature with the fiscal and service data necessary to substantiate a request for a halfway house program in Pima County. As a result of the presentation made, using the data described above, the legislature in 1971 appropriated $178,000 to purchase land and buildings for the implementation of this program which was started 8 months later.

Cost Analysis of Direct Services

Strategies can also be implemented for the analysis of expenditures for direct services. It is important to recognize, however, as illustrated by the fair-share plan described above that the importance of these types of cost analyses is not necessarily for the absolute data which they deliver to the program director, but more importantly for the value which they provide in giving a relative measure along which the service system situation can be followed and monitored over a period of time.

Tables 6-8 offer an example of this type of cost analysis. In table 6, a method is illustrated for the assessment of the fixed operating costs in a given month for each service component of the mental health center. Since the actual cost for mental health care personnel services (table 6-I) is known for each component of the mental health center, the percentage of the total cost of mental health care personnel services for that unit can be computed.

The monthly cost of all other support staff (table 6-II) and the monthly cost of all nonpersonnel operating expenses (table 6-II) are also known. The total cost of support staff and nonpersonnel operating expenses in a month is allocated to each unit on the basis of the total percentage of the mental health care personnel cost which they expend (table 6-I), yielding an operating cost for each service unit for the month (table 6-III). For example, in March 1973, the total operating cost of the outpatient unit

Table 6.—Operational cost analysis of center services[1]

I. Mental health care personnel cost

Service	*Cost*[1]	*Percent*[2]
Outpatient	$12,972	36
Walk-in	8,018	20
Day program	5,560	14
Children's	6,968	17
Halfway house	4,498	11
Consultation & education	1,819	02

II. Ancillary operational costs[1]

Support service staff	$12,542
Other operating expenses	21,484
Total	$34,026

III. Total operational cost of center services

Service	*Mental health care personnel cost (I)*	*Apportioned share of other costs (II)*	*Total operational cost*[1]
Outpatient	$12,972	$12,249	$25,221
Walk-in	8,018	6,805	14,823
Day program	5,560	4,763	10,323
Children's	6,968	5,784	12,752
Halfway house	4,498	3,742	8,240
Consultation & education	1,819	1,701	3,520

1. Per month.
2. Percent of total mental health care personnel cost.

was $25,221 in contrast to the total operating cost of the walk-in clinic which was $14,823.

These data can be compiled by the business office or a bookkeeper and are relatively stable from month to month during a single fiscal year. To complete the analysis, the utilization of the ticket (figure 1) which provides the raw data for the actual services delivered by staff members becomes important (table 7).

With the availability of the total operating cost for each unit and the total hours of direct services delivered by each unit, the program director or administrator can compute the cost per hour of direct service being delivered in each unit (table 8). Although this strategy absorbs the cost of indirect service, it is still useful as a monitoring tool over a period of time.

Significant variations in the hourly cost will alert the community mental health center program director to a need to examine service strategies for the underlying cause of this change. If the cost per service hour in a specific treatment unit should drop significantly, it might suggest a more effective utilization of the program in response to a service strategy change or an overutilization of the program suggesting a possible need for additional staff. Conversely, if the cost per service hour in a specific treatment unit should rise markedly, it might suggest an underutilization of that program requiring a service strategy change or the availability of an excessive number of staff with a possible need to transfer staff to another unit where the service need is greater.

Both of these cost analysis strategies do not require the availability of a computer-based system or an excessive number of man-hours to develop and carry out. Rather, they require primarily a dedication to self-examination, a willingness to see

Table 7.—Hours of direct service: March 1973

Units	*1st-2nd*	*5th-9th*	*12th-16th*	*19th-23rd*	*26th-30th*	*Totals*
Outpatient	70 hrs. 50 min.	265 hrs.	260 hrs. 30 min.	293 hrs. 30 min.	266 hrs. 15 min.	1,156 hrs. 5 min.
Walk-in	65 hrs. 55 min.	100 hrs. 45 min.	108 hrs. 45 min.	126 hrs. 5 min.	110 hrs. 10 min.	511 hrs. 40 min.
Day program	176 hrs. 15 min.	461 hrs. 45 min.	468 hrs. 45 min.	465 hrs. 15 min.	381 hrs. 30 min.	1,953 hrs. 30 min.
Children's	34 hrs.	102 hrs. 17 min.	70 hrs.	103 hrs. 5 min.	91 hrs. 35 min.	400 hrs. 55 min.
Halfway house	86 hrs.	138 hrs.	161 hrs.	161 hrs.	118 hrs.	664 hrs.

Table 8.—Cost per hour of direct patient services March: 1973

Service	Total hours of direct service[1]	Total operational costs[2]	Cost per hour of service
Outpatient	1,156	$25,221	$21.81
Walk-in	512	14,823	28.96
Day program	1,953	10,323	5.28
Children's	401	12,752	31.80
Halfway house	664	8,240	12.40

1. See table 7.
2. Per month (see table 6).

the community mental health service system as an integral part of a total mental health service system, and an understanding that the availability of services is not a fixed idea, but depending upon the availability of data which provide justification for change should be dynamic and subject to change in its organization and orientation.

The Impact of Evaluation

Evaluation in response to the demands for accountability is an important aspect of any community mental health service system. Evaluation carried out in the absence of adequate budgetary and staffing support becomes even more important both because of its impact on program planning and policy making as well as the gains which it can yield, thereby justifying the expenditures of even a limited portion of the budget on this nonclinical activity. Several illustrations derived from the previous examples will demonstrate how even the most limited evaluation can have a marked impact.

Impact on Staff

The impact on staff of these limited evaluation strategies can be profound. This impact can range from a simple recognition by the staff of the importance of evaluation which can subsequently help lower their resistance to participating in the evaluation process to a recognition on their part that the volume and quality of services which they are delivering are going to be evaluated and can provide useful feedback to them about the level of services which they are delivering.

For example, the awareness of the staff of the walk-in clinic regarding the poor followup of patients on referral from the Pima County Hospital emergency room to the walk-in clinic led the walk-in clinic staff itself to suggest the implementation of a new continuity-of-care system which has improved followup and continuity of care.

Impact on Administration

The impact of collecting evaluation data can have a profound impact on the administrator who is in charge of the data collection. Not only can he learn to recognize that, despite his lack of training, he can make useful insights into the nature and scope of the services which he is administering, but he will also be able to go to his staff with recommendations for programmatic change based on hard data and not solely on theoretical constructs.

For example, the availability of data regarding the paucity of group services which were being delivered, thereby yielding a high cost for the delivery of services by the outpatient unit, led the administrator to suggest to the staff that, in the future, the recruitment of personnel for that treatment team should focus on a search for individuals with specific skills in group therapy. After this was accomplished, the amount of group services being delivered by the outpatient unit increased and the cost per service hour decreased.

Impact on Legislatures and Other Funding Sources

As mentioned previously, the availability of cost analysis data can have a tremendous impact on legislatures and other funding sources. In addition to the benefits resulting from the relationship between the community mental health service system and the State hospital system, other effects of this cost analysis approach can be demonstrated.

For example, knowledge concerning the distribution of patients at the Arizona State Hospital revealed a disproportionately high number in the geriatric category. Further examinations of these data indicated that this was due in part to a lack of available nursing home and other extended-care resources in nursing homes within the community. Upon further discussion with many of the nursing home personnel, it became apparent that, although they were willing to render service to the emotionally disturbed geriatric patient, they had been reluctant to do so without professional consultation.

This suggested to the program administrator a need for a consultant to these groups. Justification for the funding of this consultant was based upon the potential impact on the hospitalization rate of geriatric patients at the State Hospital. These funds were then made available on a trial basis, and the subsequent demonstration of the impact through a reduction of the census of geriatric patients at the State Hospital has led to their continuing availability.

This example, as well as the one presented in more detail previously, illustrates the impact of even limited evaluation on legislatures and other funding resources. These evaluation strategies have also had an impact on their own funding resources by enabling the administrator, after having

demonstrated the importance of evaluation in the planning of services and in policy making, to obtain the services of an assistant with specific expertise in evaluation.

Impact on the Community

Finally, the employment of a limited evaluation strategy even in the absence of adequate budgetary and staffing support can have a tremendous impact on the community which the community mental health service system is designed to serve.

For example, the availability of hard data coupled with an effective public relations campaign can increase not only the visibility of the community mental health service system, but also its credibility among those individuals who resist seeking help at an early stage because of their fear of the stigma associated with mental illness.

The community's view of the community mental health service system as an effective organization is critical to any potential reduction of this stigma. The furthering of this viewpoint is dependent upon the availability of data which proves that this is the case. Consequently, the building of a viable community mental health service system which has credibility and visibility within the community is directly linked to the development of an effective evaluation methodology.

Summary

The implementation of effective evaluation strategies even in the absence of adequate budgetary and staffing support is critical to the maturation of the community mental health service system concept. Without effective evaluation strategies, community mental health service systems will be unable to meet the demand for accountability and will suffer a loss of credibility and funding.

The community mental health center program director or administrator who does not feel competent to undertake sophisticated evaluation strategies need not be discouraged since there are many simple evaluation techniques, some of which have been described in this paper, which can be employed to meet his responsibility for evaluation.

These techniques are simple, not costly, and are effective; but their overall implementation and success depend on the willingness of the community mental health center program director or administrator to make the basic commitment to the importance of evaluation and to transcend those underlying issues and problems which affect the development of adequate evaluation strategies.

"Evaluation on a Shoestring" can be not only worthwhile, but also effective. It can have an impact far beyond the meager one anticipated simply by a casual glance at the limited amount of funds assigned for this purpose.

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