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Full service partnership (FSP) programs were designed under the leadership of the California Department of Mental Health in collaboration with the California Mental Health Directors Association, the California Mental Health Planning Council, the Mental Health Services Oversight and Accountability Commission, mental health clients and their family members, mental health service providers, and other key stakeholders of the mental health system. Although in existence since 2005, full service partnership programs are continuing to develop the distinguishing characteristics that lead to good outcomes for mental health clients and their families.

The FSP Tool Kit is intended to provide FSP supervisors and team members with written guidance to support ongoing development of programs and integration of practices.

The FSP Tool Kit series has numerous unique characteristics that include:
Preface (cont’d)

- Development with close involvement of diverse, statewide advisory committees that represented all of California’s public mental health constituents, including clients, family members, counties, and mental health service providers.

- Identification of not only service delivery models for age-specific full service partnerships, but also an overview of practices that can be integrated into full service partnerships.

- Reference and access to website links that offer additional in-depth information on the majority of practices included in the Tool Kit.

- Recommended resources to assist in the ongoing development of full service partnership programs that support clients in their recovery.

- Performance measurement examples with each data tool.
Acknowledgements

This Tool Kit is dedicated to all the people with lived experience, whether children and their families, transition-age youth, adults, or older adults, who continually demonstrate their belief in possibilities.

This project was funded through California’s Department of Mental Health (DMH). Creation of this Tool Kit resulted from the ideas, experience, and suggestions from many groups and people throughout California. Participants from the statewide advisory committee, age-specific committees, and the performance measurement subcommittee demonstrated tireless dedication to ensure a practical outcome. Representatives from all 58 counties — through county departments, regional networks, and partner agencies — participated via meetings, conference calls, and interviews.

Additional appreciation is extended to the staff and consultants at the California Institute for Mental Health (CiMH) for their excellent leadership and compassionate guidance in this visionary endeavor.
PERFORMANCE MEASUREMENT
COMMITTEE MEMBERS
(LISTED IN ORDER OF FIRST NAME)

Alica Hendricks, MHSA Coordinator, Monterey County Behavioral Health Bureau, Salinas

Cynthia Jackson Kelartinian, PhD, Executive Director, Heritage Clinic, Pasadena

Dawn Williams, Program Planner, Sacramento County Department of Health and Human Services, Sacramento

Deane Wiley, PhD, Learning Partnership Division Director, Santa Clara County Mental Health Department, San Jose

Gregg von Fempe, LCSW, Director of Program Services, Union Station Homeless Services, Pasadena

Harriett Markell, MA, Vice President, Program and Business Development, EMQ Families First, Davis

Jaclyn Culleton, MHSA Program Manager, Humboldt County, Eureka

Karyn Dresser, PhD, Director of Research and Program Practices, Stars Behavioral Health Group, Oakland

Keith Erselius, MA, Program Evaluation Specialist, Orange County Health Care Agency, Santa Ana

Keith Harris, PhD, Manager, Research and Analysis, San Bernardino County Department of Behavioral Health

Sheila Brush, Program Planner, Sacramento County Mental Health Services, Sacramento

Tracy Herbert, PhD, Deputy Director, Sacramento, County Department of Health and Human Services, Sacramento
Acknowledgements (cont’d)

PROJECT LEAD
Cathy Bankson, MS, Senior Associate, CiMH

PRINCIPAL TOOL KIT WRITER
Dave Pilon, PhD, CPRP, President and CEO, Mental Health America of Los Angeles and CiMH Consultant

TECHNICAL WRITER
Jane Yoo, PhD, MSW, Partner, Clarus Research, Altadena, and CiMH Consultant

COVER DESIGN
Mary Ushana Williams, MBA

ARTIST
Born and raised in the Midwest, Ann Bloor was drawing tornadoes at age 4, people when she was 6 and portraits at 10. In 2000 she attended the Academy of Art in San Francisco. Her talents were challenged with her eight-year battle with mental illness and addiction, during which time she lost all her artwork. She likens the mighty phoenix of her drawing to her personal process of taking flight from the ashes on the wings of recovery and change.
Terminology

We appreciate that no one term may fit the same situation. The writers also realize that one term does not convey the same meaning in all situations. However, to facilitate the writing of this project, selection of only one expression for certain concepts became necessary. We thank the committee members who, for the sake of clarity, provided us guidance through this process.

For example, we designated the term “client” as the universal identifier for an individual with lived experience, even though we acknowledge that the term “consumer” or “person” may be more common in some areas or in some groups. Exceptions to this selected term may be found throughout the text if written within a direct quotation.

The term “program” (as in “program evaluation”) broadly describes the object of evaluation. It is a general term to describe, for instance, direct services, interventions, strategies, initiatives, and systems. Some full service partnership (FSP) programs are indeed discrete programs, but many are not and are instead more oriented as a service delivery system commonly seen in child, youth, and family mental health. Therefore, program evaluation within the
framework of this Tool Kit applies to various practices, including community mobilization efforts, administrative practices, training and education, and outreach and retention strategies. The term has broader meaning to capture the full spectrum of mental health activities within FSPs.

In the Tool Kit, the term “engagement” describes the action of bringing stakeholders into the evaluation decision-making process. Other terms such as involvement, participation, and consultation are used interchangeably to describe this action.
Introduction

As part of the development of FSP Tool Kits, the Performance Measurement Subcommittee was formed with the task of articulating a framework for performance measurement in FSP programs. In 2010 the committee drafted a white paper with a set of recommendations to enhance the current performance measurement system for FSP programs. The technical issues that are associated with performance measurement and are inherent in the recommendations are addressed in evaluation approaches commonly used in public health, education, human services, and other programs. Naturally, the optimal approach is adoption of a universal framework to resolve technical complexities related to program evaluation for a performance measurement Tool Kit.

The Centers for Disease Control and Prevention (CDC) Framework for Program Evaluation in Public Health\(^1\) (herein referred to as the CDC Evaluation Framework) is a nationally recognized framework for program evaluation. While designed originally for public health professionals, it is widely used across various fields of

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practice. The framework comprises six steps in evaluation that make up the basic elements of evaluation (as the accompanying graph illustrates). These steps are grounded in standards for effective program evaluation:

**Utility** – to serve the information needs of intended users;

**Feasibility** – to be realistic, prudent, diplomatic, and frugal;

**Propriety** – to behave legally, ethically, and with regard for the welfare of those involved and those affected; and

**Accuracy** – to reveal and convey technically accurate information.

Together, the steps and standards constitute a non-prescriptive tool for conducting program evaluation, which involves procedures that are useful, feasible, ethical, and accurate.

The six steps within the framework provide a meaningful and practical structure for the FSP Performance Measurement Tool Kit. Adapted from the framework, the Tool Kit contains six domains, and within each domain are specific evaluation topics that are relevant to FSP performance measurement.
Engage Stakeholders

As the first step in the CDC Evaluation Framework, engaging stakeholders is a critical component of program evaluation, and it is essential to a successful evaluation. A stakeholder is any person, group, or organization with a vested interest in the knowledge gained from the evaluation and the actions taken as a result of the knowledge. Without stakeholder engagement, an evaluation might miss key pieces of information about a program’s objectives, activities, and outcomes. Omitting stakeholders’ perspectives could jeopardize the credibility of the evaluation.

The evaluation process involves three principal groups of stakeholders: (1) those involved in program operations (e.g., administrators, managers, staff members, and agency partners); (2) those served or affected by the programs (e.g., clients, family members, advocacy groups, professional associations, and skeptics); and (3) primary users of the evaluation who make up a subset of all stakeholders identified (i.e., individuals who are in the position to do or decide something about the program).
Identifying Stakeholders and Ensuring Broad Stakeholder Engagement in the Evaluation Process

Purpose

To know the evaluation audience and the extent of the audience’s participation in the FSP evaluation process, and to include the perspectives of partners to address important elements of a program’s objectives, operations, and outcomes.

Definition

The explicit task of defining and identifying stakeholders is crucial to ensuring an evaluation process that is both meaningful and impactful. It clarifies roles and responsibilities and can help to avoid real or perceived conflicts of interest. Ensuring broad stakeholder engagement in the evaluation process requires involvement of the full range of stakeholders, from program promoters to program opponents.
Implementation Strategies

Know the potential stakeholders:

- Clients, primary caregivers, and family members.
- Providers, including administrators, line supervisors, and line staff.
- Allied service delivery system (e.g., child welfare, juvenile and adult probation, health, education, Area Agency on Aging, rehabilitation).
- Client advocacy groups.
- Unserved and underserved groups.
- Professional associations.
- Boards of supervisors and mental health boards.
- Legislators.
- Primary-care providers.
- General public.

Identify and define stakeholders within three groups of evaluation participants. Include program promoters, skeptics, and opponents. The three groups are:

- **Stakeholders involved in program operations** – for example: administrators, managers, staff, and agency partners.

- **Stakeholders served or affected by the programs** – for example: clients and family members.

- **Primary users** – direct users of evaluation findings to alter a program’s course (for example: administrators, managers, supervisors, line staff, providers, and funders).
Implementation Strategies (cont’d)

- Define stakeholders’ roles, as doing so helps to explicate stakeholders’ level of involvement. Consider the roles of stakeholders based on the reasons for their engagement in evaluation:
  - Will they increase *credibility* of the evaluation?
  - Will they *implement* the interventions that are subject to evaluation?
  - Will they *advocate* for changes based on evaluation findings?
  - Will they *fund or authorize* the continuation or expansion of the program?

Share the defined roles with all stakeholders to set the expectations of stakeholders’ involvement in the evaluation process.

- Create a stakeholder engagement plan, and as part of the plan, develop a matrix for guiding the evaluation process. In the matrix, identify the stakeholders and their stakeholder category, and define their role in the evaluation process. Because stakeholders may change throughout the evaluation, update the matrix regularly to maintain its usefulness as a quick reference to ensure that all stakeholders are appropriately engaged.

- Identify leaders from unserved and underserved communities, and establish relationships with them to ensure that their concerns are included in the evaluation.

- Invite skeptics and opponents to participate in evaluation forums.

- Consistently promote the inclusion of less powerful groups or individuals.

- Be aware of “hidden stakeholders” who might have been overlooked. For example, a “stalled” evaluation,” or one with many barriers and obstacles, is often a “red flag” that key stakeholders have been excluded from the evaluation process.
Focus on “early adopters” to work faster toward change. Stakeholder meetings typically encompass three groups of people among whom to promote a large shift in thinking or change regarding data or evaluation. A small percentage of people will champion the cause and become early adopters. Another small percentage will push back against change. The third group, the largest of the three, sits in the middle. Traditional thinking would make one focus on those who exert resistance to the change, causing burnout and arguments that can lead the group down a destructive path. Projecting energy toward early adopters promotes a spirit of collaboration that often is enough to move a critical mass of the middle group toward acceptance of the change being promoted.

Example of a Stakeholder Matrix for an FSP Evaluation

<table>
<thead>
<tr>
<th>Stakeholder (Individuals and Groups)</th>
<th>Stakeholder Group</th>
<th>Role in Local Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>County administrators and managers directly overseeing FSP</td>
<td>Primary user and people involved in program operations</td>
<td>To plan and implement evaluation; to engage evaluation stakeholders; to provide evaluation oversight; to work with internal and external evaluators; to extract secondary data; to clean data and offer reactions and suggestions to providers; to communicate evaluation findings; to be an evaluation participant</td>
</tr>
</tbody>
</table>

| County providers (line supervisors and staff) | Primary user and people involved in program operations | To implement the intervention or program; to offer suggestions about measurement and data collection procedures; to collect client-level data; to use findings for clinical and programmatic improvement; to be an evaluation participant |
### Implementation Strategies (cont’d)

<table>
<thead>
<tr>
<th>Stakeholder (Individuals and Groups)</th>
<th>Stakeholder Group</th>
<th>Role in Local Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community providers (administrators, managers, line supervisors, and staff)</td>
<td>Primary user and people involved in program operations</td>
<td>To implement the intervention or program; to offer suggestions about measurement and data collection procedures; to collect client-level data; to submit data to the county; to use findings for clinical and programmatic improvement; to be an evaluation participant</td>
</tr>
<tr>
<td>Clients and family members (also identify clients from unserved or underserved communities to define specific roles)</td>
<td>Served and affected by the program</td>
<td>As an evaluation participant and/or advisor, to offer reactions and suggestions about process and outcomes measures; to offer comments about implementation of FSP (including fidelity of model); to comment about measurement and data collection; to discuss the usefulness of data in their lives; to be potential advocates for change</td>
</tr>
<tr>
<td>State DMH</td>
<td>Primary user</td>
<td>To provide aggregate data submitted to the state by counties</td>
</tr>
<tr>
<td>Board of supervisors</td>
<td>Primary user</td>
<td>To reinforce evaluation goals and objectives; to use evaluation findings for sustainability and funding decisions</td>
</tr>
</tbody>
</table>
Engaging and Retaining Stakeholders in Evaluation

Purpose
To lend credibility to an FSP evaluation and to maximize the potential utilization of the evaluation.

Definition
Engaging and retaining stakeholders in evaluation lends credibility to evaluation findings. Stakeholders also bring resources in the form of knowledge and skills to help with the evaluation. They are important for myriad reasons – one of which is functioning as a potential advocate for action based on the evaluation findings. Stakeholder engagement can be a highly involved activity. Patience, time, and perseverance are some of the key ingredients to initiate movement on stakeholder participation.
Implementation Strategies

- Use a participatory evaluation approach that facilitates a partnership between evaluators and stakeholders in planning and implementing an evaluation that is focused on program improvement or organizational development.

- Engage stakeholders in the FSP evaluation process early and often to maximize the time to involve a broad set of stakeholders. Stakeholders may change in the evaluation process; therefore, engagement occurs at different phases of the evaluation and throughout the entire evaluation process.

- Establish a transparent decision-making process for managing and prioritizing the information offered by stakeholders, as a means of ensuring that the product is useful and practical. Consider other processes already in place that could serve as a model and/or could be coordinated with other statewide efforts. Determine how to ensure minimal burden while responding to various stakeholders.

- Reach out to children, their parents, transition age youth (TAY), and other atypical stakeholders, and engage them in quality improvement activities that potentially can influence their own outcomes.

- Consider key elements of successful parent engagement when engaging parents of children and youth utilizing FSP services. Such elements may include creating a welcoming environment, focusing on strengths and self-empowerment, and focusing on jointly defined outcomes.

- Mix in evaluation activities as part of other functions. This is a particularly useful strategy for small counties with limited resources. For example, use clinical meetings (e.g., multi-disciplinary meetings) with clients and line staff to discuss applicable evaluation findings, as well as to discuss the evaluation process. This strategy leverages existing meetings and obviates the need for separate meetings for evaluation purposes.
Implementation Strategies (cont’d)

- Use skilled facilitators to prepare for and conduct evaluation meetings. Allow facilitators to prepare stakeholders in advance. Preparation will vary for different stakeholder groups. Skilled facilitators explain clearly the expectations of stakeholders and the decision rules for stakeholder feedback. Management of expectations about what can be evaluated and how findings will be used is critically important.

- Be clear in explaining to stakeholders the purpose and goals of stakeholder participation. Clarify the advantages of stakeholder engagement. Describe the potential benefits of stakeholder engagement for program and/or practice improvement.

- Allocate paid positions for stakeholders as a strategy for involving clients, their caregivers, and family members. Also, consider this strategy for stakeholders who are minimally involved in services. Create incentives – both monetary and non-monetary – to promote participation.

- Build individual relationships with stakeholders, and use these associations to build other relationships.

- Leverage existing resources to involve stakeholders in the evaluation process. Numerous programs throughout the state demonstrate ways in which to engage stakeholders in decision-making processes. The MHSA planning process, for example, enabled counties to build a foundation for stakeholder participation. Governance councils constitute other existing resources. That is well illustrated by Monterey County, which worked with stakeholder members of the council to guide a longitudinal study that involved children and youth in evaluation, as well as parent partners of children and youth.
Institute regular check-ins with agency partners and other collaborators. Use online surveys (e.g., Survey Monkey and Qualtrics) to solicit feedback on evaluation progress and technical assistance needs, and e-mail updates about evaluation progress to stakeholders.

Consider offering food, transportation, stipends to cover expenses (such as child care and travel), and other incentives to involve stakeholders in evaluation meetings.

Example of Engaging Clients in Quality Improvement Activities

| The challenge: | Program staff members had difficulty tracking participation and progress among members of a peer support and recovery center for TAY. In periodic satisfaction surveys, clients reported few outcomes regarding housing, education, and jobs. |
| The solution: | Based upon suggestions of the client steering committee and peer advocates on staff, the center instituted a self-directed recovery plan (SDRP) to encourage members to identify and focus on their life goals, and to engage them in tracking participation and progress in achieving life goals. |
| The results: | Since implementation, data on the SDRP ratings indicate an increase in the number of new members participating in initial goal setting, and a sizable subset of clients reporting steady progress. Attendance in center activities also increased since implementing the SDRPs. Finally, client-perceived outcomes increased, suggesting that members’ service encounters (e.g., with a vocational counselor) may be more meaningful and impactful now they relate more clearly to their self-defined goals as tracked by the SDRP. |
Implementation Strategies (cont’d)

Broadening the Stakeholder Base: Examples from San Francisco County

Strategies for engaging traditional and nontraditional stakeholders in the evaluation process include these examples:

- Monthly meetings with FSP providers offer an opportunity to engage stakeholders in the evaluation process. The county generates program- and client-level reports from the Data Collection and Reporting (DCR) system, and shares that information with providers in monthly meetings. That approach enables comparison of reports, program by program, in a process in which providers can ask questions, solve problems, and learn from others. Providers have reported that they use the DCR reports for case conferences, one-on-one supervision, and improving DCR client data quality.

- Clients are involved in these or other regular meetings to help clarify data and reports, particularly on residential settings. In the past, clients have supplied information that has helped determine how to classify certain San Francisco housing units under categories defined by the California DMH. For example, clients helped articulate the distinction between an apartment and an SRO (single-room-occupancy) hotel, in which two adjoining units typically share a bathroom. Overall, client voice is critical. Clients’ priorities are weighed in the decisions about which outcomes to address and how they are represented in reports.

- In January 2010, the MHSA Community Advisory Committee established a workgroup to evaluate all MHSA programs. The Evaluation Workgroup is a forum in which program representatives and providers can share evaluation plans, tools, and descriptions of program activities; can solicit and discuss feedback from clients; and in a group setting can access evaluation technical assistance from the county’s community programs research and evaluation team of epidemiologists and program evaluators. Group discussion enriches evaluation strategies and aids in refining data collection tools. Participants express a sense of camaraderie among colleagues working on similar projects, and clients benefit from building their own understanding of evaluation while contributing insights to the discussion. This is an example of how resources that are internally available to the county are shared with external stakeholders to encourage participation in the evaluation process. Clients who might not otherwise have been identified as interested stakeholders have demonstrated considerable interest in the evaluation workgroup.
Purpose

To engage a diverse stakeholder base using strategies that are culturally inclusive and appropriate.

Definition

Successful engagement enhances cultural proficiency and increases protection for human subjects who may be involved in the evaluation. *Culturally proficient stakeholder evaluation* includes evaluators who foster input, participation, and power-sharing among all those who have an investment in the evaluation and the findings.
Implementation Strategies

- Invite stakeholders who understand the cultural aspects of a program or system of care. Before inviting stakeholders, think through the question “Why is this worth their time?” Verify with them the validity of any assumptions that may have been made.

- Be candid with stakeholders from unserved and underserved communities. Explain the evaluation process clearly. Transparency enhances competencies across the board.

- Value and respect the contributions of those who represent community members; treat them as experts of their community; and share power in the evaluation process.

- Encourage underrepresented stakeholders to bring resources (e.g., their knowledge of cultural practices, or client satisfaction outcomes measurement instruments that were developed by and for a specific cultural group). At the same time, offer ways to teach evaluation skills to stakeholders and members of their communities.

- Create opportunities through which diverse communities that are segregated can come together. Use these gatherings for networking, building trust, and sharing resources around evaluation and other actions.

- Find champions and gatekeepers who could communicate with cultural groups to help identify client or community needs. These champions and gatekeepers may have critical connections to representatives in the community who are not the same people who are always involved. Seek advice on cultural issues that are important to know in identifying new leaders or representatives. For example, Monterey County works with Latino leaders to increase credibility and engagement of underserved Latino communities in planning, implementation, and evaluation.
Implementation Strategies (cont’d)

- Use “power brokers” (i.e., important individuals representing constituent groups such as clients and service providers) to help frame evaluation around service planning; this strategy can encourage participation in the evaluation process and broaden the stakeholder base.

- Encourage stakeholder and client buy-in with respect to evaluation by training line staff on cultural competency and proficiency.

- Train staff to explain research procedures clearly to parents, and to explain to parents that all children are to follow the same procedures.

- Develop bilingual evaluation materials.

- Minimize the use of evaluation jargon by reframing key terms like “outcome” as “how well your child is doing in school.” Use an asset-based or strengths-based approach to communicate evaluation processes with unserved and underserved populations.

- Go to the stakeholders rather than asking them to come to the agency (i.e., the county office or agency). Approach them first as a potential resource, instead of waiting to go to them at a time that is convenient for the provider.

- Invite stakeholders to an activity versus a business meeting. Stay action-oriented while encouraging stakeholders to enjoy the event, activity, or potluck. Allow sufficient time for participants to mingle.

- Serve food at gatherings, meetings, and activities. Food embodies a significant cultural component.

- Systematize the involvement of diverse stakeholders, especially those from unserved or underserved communities, so that their efforts are neither
Implementation Strategies (cont’d)

construed as token nor are, in real practice, token involvement. Integrate into the continuous quality improvement process the involvement of stakeholders through focus groups or face-to-face interviews that are conducted regularly. Further, involve underrepresented stakeholders in governance to properly vet expectations about performance measurement and performance standards.
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 30–33. This guide enables you to focus on the pertinent resources linked directly to each tool.

<table>
<thead>
<tr>
<th>Name of Tool</th>
<th>Resource Number(s)</th>
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<tbody>
<tr>
<td>Identifying Stakeholders and Ensuring Broad Stakeholder Engagement in the Evaluation Process</td>
<td>1,11,14</td>
</tr>
<tr>
<td>Engaging and Retaining Stakeholders in Evaluation</td>
<td>3,4,5,6,7,9,10,12,16,17,18</td>
</tr>
<tr>
<td>Culturally Proficient Stakeholder Evaluation</td>
<td>2,8,13,15</td>
</tr>
</tbody>
</table>
Articles


Books


✔ **Guidebook**


✔ **Manuals**


✔ Periodical


✔ Policy Brief


✔ Reports


✔ Tool Kit


✔ Workbook

Describe the Program

The second step in program evaluation is to describe the program in clear, achievable, and measurable terms. A strong program description is important because it articulates and documents a common vision as it details the mission and objectives of the program. Program descriptions establish clarity and consensus about the program purpose and intended effects, and they enable evaluation to identify shortcomings in the program early on. Clarity on a program’s goals and objectives can benefit the planning of data collection and ultimately, the use of evaluation findings. Key aspects to include in a program description include: need, expected effects, activities, resources, stages of development, context, and a logic model.
Developing a Statement of “Need” in FSP Programs

Purpose
To describe the problem or opportunity that the FSP program addresses.

Definition
The process of developing a statement of “need” in FSP programs should include defining the nature and magnitude of the problem or opportunity the program addresses. What is the problem or opportunity that the program addresses? What are the nature and magnitude of the problem or opportunity? What population is affected? Is the need changing, and if so, in what manner?
Implementation Strategies

- Develop a strong statement of need by:
  - Describing the nature and magnitude of the problem or opportunity.
  - Describing the target population(s) that is or are affected and that need to be served.
  - Relating the problem or opportunity to the purposes and goals of the organization.
  - Including quantitative and qualitative documentation and supporting information (while being judicious in the selection of data or information).
  - Avoiding making any unsupported claims or assumptions.
  - Describing the situation in terms that are both factual and of human interest.
  - Describing whether the need is changing and in what way the need is changing.

- Use culturally appropriate language in a statement of need. For example, in a child, youth, and family FSP program, terms and concepts such as *discovery, resilience, and promoting positive youth development* are appropriate and meaningful, whereas adult mental health terms like *recovery* and *wellness* may be less useful.

- Use strengths-based language to describe the need, especially regarding unserved or underserved populations that are historically characterized using deficit language. Using strengths-based language includes framing the need in terms of identifying assets and building capacity. For instance, in reference to children, youth, and family programs, strengths-based language sets the tone for defining children’s outcomes in terms of increasing protective factors while simultaneously reducing risk factors.
Implementation Strategies (cont’d)

- Address disparities when working with ethnic populations. For example, describe disparities in access to and utilization of mental health services, and put into perspective the disparity by looking at penetration rates as they compare to the larger racial and ethnic composition of the county.
Defining the Expected Effects of FSP Programs

Purpose
To articulate the program effects or changes that are expected.

Definition
Defining the expected effects of FSP programs involves describing the expected changes the program aims to achieve. Because the effects of most FSP programs are expected to unfold over time, expected effects are organized and presented as short-term, intermediate, or long-term outcomes.

- **Short-term** outcomes are the direct results of program activities. Typically, short-term outcomes indicate a change in knowledge, attitudes, motivations, and skills.

- **Intermediate** outcomes are achieved in part by short-term outcomes. Typically, intermediate outcomes indicate changes in behavior, decisions, and policies.
Long-term outcomes are achieved in part by short-term and intermediate outcomes. Typically, long-term outcomes indicate a change in individual or group behavior or community conditions. Long-term outcomes reflect a larger social consequence.
Implementation Strategies

- Use the program’s mission statement and description of goals and objectives to articulate the expected effects. Goals and objectives align to expected effects, which are specific, achievable, and measurable. Expected effects or outcomes typically are favorable for the people whom the organization aims to benefit through its programs or services. Outcomes often are specified in terms of *learning* (including enhancements to knowledge, understanding, perceptions, attitudes, and behaviors), *skills* (behaviors to accomplish results, or capabilities), and *conditions* (including increased security, stability, and pride).

- Anticipate potential unintended effects of the program.

- Define expected effects in terms of short-term outcomes, intermediate outcomes, and long-term outcomes.

- Use existing resources – such as the age-specific FSP Tool Kits and the Data Collection and Reporting (DCR) system – to define expected effects of FSP programs.

- Identify outcomes that might beneficially include allied service delivery systems. For example, broaden children’s mental health outcomes to include outcomes related to permanency, juvenile delinquency, and education. Because allied service delivery systems often are an integral part of children’s FSP services (e.g., child welfare, probation, education, and health), outcomes based on the intersection of these systems are highly relevant.

- Apply the constructs of recovery and wellness in defining outcomes for FSP programs (refer to Appendix A). Define relevant outcomes for racially, ethnically, or culturally diverse clients in an FSP program that is culturally targeted. Engage stakeholders in the definition of these outcomes, and seek the help of stakeholders to develop culturally appropriate instruments to measure these outcomes. Also, define outcomes related to the common good. In some cultures, the “collective outcome” holds more meaning than the “individual outcome.”
Implementation Strategies (cont’d)

- Remember that the outcomes of a program need to be measurable. Therefore, personnel in smaller counties and their partner agencies that have limited resources should consider the staff and time commitment of collecting and analyzing data when setting outcomes that are multi-leveled (client, agency, community, and policy).

- Differentiate outputs from outcomes. Outcomes are the results of outputs. Outputs are program processes such as the number or percentage of mental health screenings. The output of mental health screenings hypothetically results in proper diagnoses. Screening is a service that is offered as a means of achieving a proper diagnosis. Being properly diagnosed leads to receiving the right kinds of services for the condition, which increases the likelihood of achieving desired results of treatment. (For more information on how outputs and outcomes are related, consult the “Developing a Logic Model for FSP Programs” Tool.)

Examples of Expected Effects

<table>
<thead>
<tr>
<th>Program for Transition Age Youth (TAY) with Substance Abuse and Mental Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Short-term outcomes:</strong></td>
</tr>
<tr>
<td>• Improved knowledge of effects of substance abuse</td>
</tr>
<tr>
<td>• Reduction in substance abuse</td>
</tr>
<tr>
<td>• Reduction in mental health symptomology</td>
</tr>
<tr>
<td>• Improved involvement and support of family members for TAY</td>
</tr>
<tr>
<td><strong>Intermediate outcomes:</strong></td>
</tr>
<tr>
<td>• Avoidance of entry into juvenile justice system</td>
</tr>
<tr>
<td>• Graduation from high school</td>
</tr>
<tr>
<td>• Gaining employment</td>
</tr>
<tr>
<td>• Reduction in hospitalization (or avoidance of hospitalization)</td>
</tr>
<tr>
<td><strong>Long-term outcomes:</strong></td>
</tr>
<tr>
<td>• Reduction of incarceration rates for people with mental illness</td>
</tr>
<tr>
<td>• Stable, long-term employment</td>
</tr>
</tbody>
</table>

Examples continued on next page
Adult Program for People with Severe and Persistent Mental Illness and History of Homelessness and/or Incarceration

**Short-term outcomes:**
- Securing housing
- Improved access to health care
- Improved social support networks
- Reduced harm from substance abuse
- Increased use of psychotropic medication and other means of reducing symptomology

**Intermediate outcomes:**
- Decreased symptomology and decreased symptoms distress
- Improved financial resources (SSI and Medicaid enrollment)
- Accurate physical health-related diagnoses and treatment
- Increased involvement in social activities

**Long-term outcomes:**
- Reduction in homelessness rates among older adults with severe and persistent mental illness
- Reduction in incarceration rates
- Increase in independent living rates
- Elevated employment rates
- Increase in education rates
- Improved mortality and morbidity rates

Older Adults Program for Homelessness and Severe and Persistent Mental Illness

**Short-term outcomes:**
- Securing housing
- Improved access to health care
- Broadened spectrum of social support networks
- Increased use of psychotropic medication and other means of reducing symptomology

**Intermediate outcomes:**
- Improved financial resources (SSI and Medicaid enrollment)
- Accurate physical health-related diagnoses and treatment
- Increased involvement in social activities

**Long-term outcomes:**
- Reduction in homelessness rates among older adults with severe and persistent mental illness
Defining the Activities in FSP Programs

Purpose
To identify core program activities that are logically linked to the expected effects of the program.

Definition
Defining the activities in FSP programs includes describing the services, activities, and interventions applied to effect desirable change. What is the program’s hypothesized mechanism for effecting change? How does each program activity relate to another? Are related programs or partners responsible for any of the program activities? What external factors (e.g., lack of community involvement, political pressures) might affect the program’s success?
Implementation Strategies

- Include in the program description any activities that are key ingredients of the intervention to effect change. For example, identify products (e.g., promotional materials and educational curricula) and infrastructure (e.g., relationships and capacity) as program activities.

- Use existing resources – such as the age-specific FSP Tool Kits and the FSP Practices Scale – to describe the activities in FSP programs.

- Make the description of activities specific enough to explain how activities will achieve the expected effects or outcomes.

- Explain necessary cultural accommodations. For example, the product might consist of pamphlets that are designed for lesbian, gay, bisexual, transgendered, and questioning (LGBTQ) youth. These pamphlets are used in outreach for mental health screening, which is a primary service. The organizational infrastructure is strengthened by the relationships fostered among staff members, LGBTQ youth already in the program, and prospective LGBTQ youth through special events to recruit young people for the screening.

- Clearly describe the activities in child, youth, and family FSP programs to delineate whether activities are specifically targeted to children rather than parents, or to the family as a whole. Correspondingly, for adult FSP programs delineate activities for clients and their families or primary caretakers. Establishing those distinctions is important because activities are intrinsically linked to outcomes, and outcomes might be defined differently for the various units within a family.
Examples of Activities

**Children’s Program:**
- Offer individual and family counseling at home, school, or in a community setting.
- Provide peer support from people who have had similar experiences.
- Furnish transportation.
- Assist in accessing physical health care.
- Find suitable housing for children and families.
- Assist in obtaining financial and health benefits for children and family members who are eligible.
- Provide substance abuse and domestic violence counseling and assistance for family members as needed.
- Conduct these services in a linguistically and culturally appropriate manner.

**Adults’ Program:**
- Provide counseling at home, school, or in a community setting.
- Assist in accessing physical health care, including proper medication.
- Help with securing housing.
- Assist with finding employment.
- Establish peer and caregiver support groups.
- Assist in obtaining eligible financial and health benefits.
- Assist with arranging medical appointments.
- Furnish transportation (e.g., to medical appointments).
- Treat substance abuse.
- Perform these services in a linguistically and culturally appropriate manner.
Identifying Resources in FSP Programs

Purpose
To have resources available to execute program activities.

Definition
Identifying resources in FSP programs means compiling information about facilities and personnel ranging from staff composition to meeting spaces that are available to conduct program activities. This information can include time, talent, technology, equipment, funding sources, and other assets. Some questions for consideration may include: (1) What kinds of program services are offered and what are their frequency and duration? (2) Are the desired activities and available resources mismatched? (3) What are all the direct and indirect program inputs and costs?
**Implementation Strategies**

- Be specific about resources. If staff persons constitute a key resource, specify the functions and capabilities of staff members (e.g., direct service staff with certain qualifications), how many staff members are available, and how much of their time is needed (e.g., full-time vs. part-time). Further, if the competency of staff persons who perform direct services is an essential component of the intervention, highlight this resource. For example, explain the critical importance of staff empathy in working effectively with clients of FSP services. Describe the necessary staff qualities or the training of staff that is an essential element of the intervention, including whether staff members are trained and certified in evidence-based practices (EBPs) relevant to the program design.

- Identify resources that are linked to success in working with unserved or underserved populations. For example, define the linguistic capabilities of the staff to meet the language needs of clients. If services target Spanish-speaking clients, stipulate the organizational capacity to meet this language need. Share other relevant aspects of cultural competency training and initiatives.

- Include clients and their families as resources, and explain how they will be supported to be effective in their unique roles.

- Include resources that partners or collaborators supply. These resources may be particularly important to small counties relying on partners to leverage existing resources.

- Juxtapose the list of resources with the list of activities to determine the existence of any mismatches between resources and activities. Such discrepancies could explain why expected effects are not achieved.
Examples of Resources

Examples of Resources in FSP Programs:

- MHSA funding
- County staff
  - Administrative and managerial personnel
  - Direct service providers, including psychiatrists, psychotherapists, and counselors
  - Specialized staff members, with bilingual, bicultural, information technology, or other expertise
- Community providers
  - Administrative and managerial personnel
  - Direct service providers, including psychiatrists, psychotherapists, and counselors
  - Specialized staff members with bilingual, bicultural, information technology, or other expertise
- Family members and caregivers
- Parent advocates and youth mentors
- Resources from allied service delivery systems – for example:
  - School resources such as teachers and principals
  - Health-related resources such as primary-care physicians and nurses
  - Organizational resources (e.g., Area Agency on Aging)
  - Suitable placements for children and youth
- Professional associations
- Client advocates
- Local government entities (e.g., housing authority)
- Government entitlements (e.g., Medi-Cal, Medicare, SSI)
Understanding the Stages of Development

**Purpose**

To determine the program’s changing maturity or program practice during the evaluation process.

**Definition**

*Understanding the stages of development* helps to define the goals of the evaluation. A program’s stage of development reflects its maturity. What is the developmental stage of a program? Its stage – for example, in planning, implementation, or effects – defines the goals of evaluation. A program in its planning phase might use evaluation to refine its plans. A program in its implementation phase might use evaluation to improve operations. During evaluation, the goal might be to identify and explain the intended (and unintended) effects of the program.
Implementation Strategies

- Begin the evaluation process by determining the program’s stage of development. Recognize that not all programs move through all the stages. The evaluation process encompasses a minimum of three stages: planning, implementation, and effects. Some models of development suggest additional stages. For example, in between the planning phase and the implementation phase is a pilot phase, and after the program has reached its mature phase, it may enter a phase-out or termination stage.

- Be cognizant of the stages to avoid making poor inferences about the effectiveness of a program by expecting too much too soon or not expecting enough. Seasoned evaluators understand that new program models typically require two or three years of run time, to iron out shortcomings and refine operations, before commencing evaluation of the impact of the model.
Purpose

To describe the sociological and historical context within which the program operates.

Definition

*Considering the context of FSP programs in program descriptions* encompasses the broader policy environment and social ecology of the service population, as well as the specific history, geography, and setting within which the program operates. An understanding of the context – the setting within which the program operates – informs the design of a context-sensitive evaluation. What is the historical context of the program? What social and economic conditions influence the program’s operations?
Implementation Strategies

- Describe components of the FSP program that go beyond services. These are components also hypothesized to affect the intended outcomes – for example:

  - **Social support networks** for clients are contextual to FSP programs because individuals within these networks influence clients. An important social ecology of mental health clients is social isolation from stigma, either internalized or experienced in their interactions with others. Whether social isolation is perceived or actual, or both, clear understanding of this context results in better planning for program activities – such as steps to address stigma and support socializing – as well as determination of why or why not outcomes were achieved.

  - **Organizational culture and climate** (e.g., supervisor support, cooperation and collaboration internally and across partner agencies, leadership, and staff burnout) are potentially strong determinants of outcomes. Culture and climate make up the environment within which the program operates. The degree to which an organization is hospitable to staff and clients alike has implications for how a program operates and ultimately, how outcomes are influenced. An example of this is the study done by Gowdy, Carlson, and Rapp (2004)\(^1\) in which high-performing and low-performing supported employment programs were compared. Among other things, the study found that supported employment programs were more likely to be successful in increasing the employment of their participants if they exhibited an organizational culture that encouraged the desire and motivation of people in recovery to work and nurtured leaders who emphasize the value of work and the belief that people in recovery can work.

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Implementation Strategies (cont’d)

- **Inter-organizational relationships** are important contextual factors for programs, particularly those that are inter-dependent for clients and resources. For instance, children, youth, and family FSP programs are systems-driven; therefore, the relationship between service delivery systems is a critical context under which they operate. Systematic barriers may inhibit achievement of outcomes or permit only marginal achievement. Such suppressions include limits that high caseloads exert on child welfare workers’ time and attention to enrolled clients, or obstacles that probation staff members encounter as a result of a juvenile court judge emphasizing punishment over treatment of adolescent offenders who have mental health problems.

- **Neighborhood and community factors** affect programs directly and indirectly. FSP programs operate in communities; therefore, describing the community (e.g., its support of lack thereof for FSP) is essential in understanding the program. For example, administrators of FSP programs that serve an ethnic minority group in a community known for housing discrimination should seriously consider this context in implementing the program.

- **Political factors** – local, statewide, or national – influence not only program funding but also program practice and evaluation. Recognizing these factors and their potential impact on the program provides a context for understanding the external forces that positively or negatively sway the expected effects of a program. For example, if effective services take multiple years to evolve, yet policy makers and taxpayers are seeking to identify funding to cut now, then evaluators might attend to process measurements to communicate whether programs are on the track toward achieving legislated outcomes.
Implementation Strategies (cont’d)

- Consider the relationship of FSP programs to other programs or practices in describing how FSP programs intersect with countywide or statewide initiatives. As more and more MHSA values are being integrated into systems-wide initiatives, FSP becomes incrementally less isolated. As an example, the San Francisco Department of Public Health (which administers the Community Behavioral Health Services unit) combines FSP and Intensive Case Management services in an administrative analysis of how the services merge.
Developing a Logic Model for FSP Programs

Purpose

To create a visual depiction that captures the key elements of a program.

Definition

The process of developing a logic model for FSP programs includes creation of a tool to depict a road map of a program, typically in the form of a flow chart, map, or table that portrays the logical sequence of steps leading to program results. The model links context, needs, and goals to activities, resources, and development, with respect to intended and measured outcomes. In documenting expected effects or outcomes, this tool identifies what works and why.
Implementation Strategies

- Utilize various resources and the examples in these resources to develop a logic model. There are two types of logic models: theory of change and program. The theory of change logic model is conceptual and presents an overview with little detail, and the program logic model is operational and typically more detailed. Logic models vary in the elements they depict, but generally they include these elements:
  - **Inputs** – the resources available to the program (e.g., staff).
  - **Activities** – program strategies (e.g., mental health screening).
  - **Outputs** – the amount of product or service that the program intends to furnish (e.g., number of people completing group counseling).
  - **Results** – the short-term (e.g., securing housing), intermediate (e.g., reduction in homelessness rates), and long-term outcomes (e.g., improvements in housing regulations for persons with mental illness).

- Include contextual factors in the logic model, such as political pressure or community engagement if they are particularly relevant to a program. Contextual factors usually are indicated in boxes at the bottom of the logic model. Other elements in the logic model include a brief description of the target population and a statement of program purpose (i.e., mission or program goals and objectives).

- Involve stakeholders in the development of the logic model. Verify the accuracy of the information in the logic model by involving diverse stakeholders.

- Present an opportunity for stakeholders – specifically, providers – to discuss program descriptions and logic models. The process of sharing program descriptions and logic models promotes transparency and inter-organizational learning. The actual process of developing logic models offers highly participatory learning opportunities.
Implementation Strategies (cont’d)

- Use the logic model to strengthen any claims of causality by linking the causal chain when expected effects are not directly measured.
- Revisit the logic model after developing it, and review it for program monitoring purposes.
- Use logic models to inform evaluations. For example, the outcomes identified in the logic model should be the outcomes measured in the evaluation.
- Strive for simplicity when developing a logic model. Show the main pathways between the program and its presumed outcomes.

Examples of Logic Models

**EXAMPLE 1.** This example of a theory of change logic model for a generic recovery model was developed by Mental Health America Los Angeles for the MHA Village Program for Adults in Los Angeles County. An explanation of the logic model precedes the logic model diagram.

The relationship between a program’s structure and practices and client outcomes can be visualized in this logic model. The logic model begins with the inputs of any system’s or program’s stakeholders and the mission and resources they bring to endeavor. Different inputs result in different program cultures in which the general practices (the therapeutic relationship and organizational factors like a welcoming environment) and the specific practices (the treatments and services) are embedded. If these practices are effective, they will result in outcomes such as the internal experience of “hope” and “empowerment,” as well as long-term changes in the client’s external quality of life, such as an increased tenure of living in the community and increased job tenure.

In this model, practices can have a direct impact on both internal and external outcomes. This runs slightly counter to the traditional therapeutic expectation that a client must experience internal change before long-term external changes can occur. Indeed, the model suggests that internal and external outcomes have a bidirectional relationship in which each can influence the other. In practical terms, it reflects a belief that advancing from homelessness into an apartment can produce an experience of hope to at least the same degree that a person who becomes more hopeful about life can be inspired to transcend homelessness and move into his or her own apartment.
Implementation Strategies (cont’d)

**Input**
Mission
Clients
Staff
Resources

**Program Culture**
Therapeutic relationship
Treatment and services (EBPs)

**Internal (Client) Outcomes**
 Increased skills and functioning
“Recovery” (empowerment, hope, self-responsibility)
Decreased symptom distress
Decreased substance abuse

**External (QOL) Outcomes**
 Increased residential independence and stability
Reduced hospitalization
Reduced incarceration
Increased employment
Increased education
EXAMPLE 2. This is an example of a program logic model for the AVANZA program, which is a youth-guided Monterey County program with a comprehensive array of services based on each youth’s strengths and needs.

[Click “zoom” to enlarge the chart and make it more legible.]
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 61–64. This guide enables you to focus on the pertinent resources linked directly to each tool.

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<tr>
<th>Name of Tool</th>
<th>Resource Number(s)</th>
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<tr>
<td>Considering the Context of FSP Programs in Program Descriptions</td>
<td>1</td>
</tr>
<tr>
<td>Developing a Logic Model for FSP Programs</td>
<td>7,8,9,10,13,22</td>
</tr>
</tbody>
</table>
✔ **Article**


✔ **Books**


Data Collection Instrument

6. Gilmer, T. *The FSP Practices Scale*. University of California, San Diego. For a copy of the scale or for more information on the scale, contact Todd Gilmer at tgilmer@ucsd.edu or 858-534-7596.

Guidebooks


Online Course

10. Enhancing Program Performance with Logic Models (online course developed by the University of Wisconsin). Downloaded from http://www.uwex.edu/ces/Imcourse/

Manuals


✔ Periodical


✔ Tool Kits – FSP


Tool Kits: FSP – Cultural Relevance


Websites


Focus the Evaluation

To focus the evaluation is to be clear about its purpose. Clarity about the purpose of the evaluation is critically important because it sets the stage for generating the evaluation questions and study design. Based on the CDC Evaluation Framework, the function of conducting FSP evaluations serves four general purposes: (1) gain insight, (2) change practice, (3) assess effects, and (4) affect evaluation participants and audiences.

The California Department of Mental Health has proposed a framework for the evaluation of the MHSA. This framework includes three levels of performance measurement – individual client level, mental health system accountability level, and public/community-impact level – of which the initial two, addressed in this domain, are county responsibilities.

3 The framework can be found in the California Mental Health Planning Council (January 2010) report: Performance indicators for evaluating the mental health system. Retrieved from http://www.dmh.ca.gov/Mental_Health_Planning_Council/docs/PerformanceIndicatorProposalfinal.pdf
Gaining Insight

Purpose

To determine the feasibility of adopting a new approach and/or to clarify how activities will be designed to achieve expected outcomes.

Definition

Knowledge obtained from an evaluation focused on gaining insight could reveal important information on, for example, the practicality of adopting a new approach to FSPs or designing a set of program activities that will be evaluated at a later time for their effectiveness. This type of evaluation is designated a “formative” evaluation. Formative evaluations are intended to yield knowledge that could be used for program development. (Formative evaluations also are used for program improvement. Refer to the “Changing Practice” tool.)
## Implementation Strategies

- Conduct evaluations with the purpose of “gaining insight” as part of the process of developing a new program or adding a new program activity to an existing program.

Two examples of evaluations that are intended to gain insight are shown here. Sample evaluation questions accompany these two examples:

### Example 1 – Housing Component for TAY

**Purpose:** A housing component of an existing FSP program for TAY is under development. This evaluation will explore program options for incorporating a housing component into the TAY FSP program.

**Process:** An evaluation that is intended to yield insight could involve speaking to current or potential clients about the activities that should be implemented to achieve the outcome of housing stability. The evaluation might include reviewing documents on existing housing programs for TAY. Or it might include focus groups consisting of current clients discussing program activities that are desirable for the housing component.

**Sample evaluation questions:**

1. What are the best practices in housing programs for persons with mental illness?
2. What components of housing programs are most relevant to TAY?
3. What features of housing programs are most or least appealing to TAY?
4. What are the typical costs and resources needed to implement a housing component?
Implementation Strategies (cont’d)

**Example 2 – Service Utilization in FSP**

**Purpose:** A new FSP program for older Latino adults is under development. This evaluation will explore the barriers to and facilitators of FSP service utilization among older Latino adults with mental illness.

**Process:** An evaluation that is intended to yield insight could identify barriers to and facilitators for service utilization. This evaluative information would help in designing program components in a way that optimizes service utilization. The evaluation might include interviews with clients of mental health services and staff members who have worked with clients representing the target population. The goal of such an evaluation would be to identify strategies for service access, utilization, and client retention.

**Sample evaluation questions:**

1. What cultural factors need to be considered when determining ways to improve service utilization?
2. What are the best practices in engaging and retaining older Latino adults in mental health services?
3. Can you discern systematic barriers to and facilitators for service utilization of mental health services?
4. Which particular supports (informal and formal) for the target population need to be consolidated to ensure greater utilization of services?
Purpose
To determine the impact of change during the implementation of a program.

Definition
Changing practice refers to an established program’s implementation stage during which the provider seeks to describe what it has done and to what extent it has succeeded. If an FSP program is being newly implemented, for example, this is a good time to start an evaluation that is intended to change practice. This type of evaluation often is designated a “formative” evaluation. Formative evaluations are intended to generate knowledge that could be used for program development and improvement.

Examples of evaluation for the purpose of changing practice may include:

- Refining plans for introducing a new FSP service.
- Characterizing the extent to which FSP intervention plans were implemented.
Definition (cont’d)

- Improving the content of education materials for FSP clients and family members.
- Enhancing the FSP program’s cultural competence.
- Setting priorities for FSP staff training.
- Making midcourse adjustments to improve client engagement and retention in an FSP program.
- Determining if client satisfaction rates can be improved.
- Mobilizing community support for the FSP program.
Implementation Strategies

Overall implementation strategies are listed initially. Suggestions for smaller counties or counties with limited evaluation resources are listed in the next section of these implementation strategies.

- Monitor program fidelity. Each FSP program is based on a practice model. Using a logic model of the program, monitor its fidelity in terms of whether implementation is indeed as intended and depicted in the logic model. Fidelity studies not only help to show the extent to which implementation is true to the program’s design, but also help to explain the outcomes. For example, inability to achieve outcomes might be explained by a fidelity study that showed that implementation deviated significantly from the program design. Adopt or adapt existing instruments to measure fidelity, such as the FSP Practices Scale and the Assertive Community Treatment (ACT) Fidelity Scale.

- Examine FSP practices. Either as part of a fidelity study or a separate study, evaluate what the practices are. Look at the FSP Tool Kits to identify the core practices that make up the FSP program. Assess these practices as part of quality assurance and/or improvement activities, and use the evaluation findings to understand why outcomes were or were not achieved.

- Consider the role of family members and other supports. Evaluation of the role of the family and other supports in achieving program goals is important, especially in child, youth, and family FSP programs. If the program logic model indicates that family members constitute a critically important resource and are an integral part of the program activities and outputs, those family members should be included in the evaluation. In a system-of-care approach using wraparound principles and practices, family members (along with other partners such as allied service providers)
Implementation Strategies (cont’d)

should be included in the evaluation as a single unit or as multiple units encompassing parents and children. For instance, in asking the question about “voice and choice,” evaluators might seek to understand the extent to which clients (i.e., children or youth) as well as other family members (e.g., parents or grandparents) exercised “voice and choice.”

- Study client demographics with respect to service goals. This approach helps to determine disparities in access, utilization, and outcomes. For example, examine penetration rates or service utilization rates by race or ethnicity, target population, and gender.

- Assess the operational environment of FSP implementation. The operational environment might explain variations in outcomes. This assessment should incorporate these considerations:
  - Have funding cuts been made to the program?
  - Have organizational changes affecting staff and/or the program taken place?
  - Have any policy changes affected the program?

- Measure organizational culture and climate. The organizational culture and climate of the FSP agency or set of agencies implementing FSP services certainly have a significant impact on program outcomes. Measure these constructs as a way to understand the organizational context of client outcomes. For example, explore staff attitudes about the “whatever it takes” principle in FSP. Or assess the extent to which administrators and staff members believe that people in recovery have the desire to work and are capable of attaining steady employment.

- Explore “community connectedness.” The mental health service delivery system operates within a larger context of community resources – whether
Implementation Strategies (cont’d)

they are allied service delivery systems or community resources (e.g., churches, nonprofit organizations, or foundations) that are unaffiliated with these formal systems. Explore the extent to which the FSP program is connected to the community in a way that supports its goals and objectives – not only for its operations but also for client outcomes.

- Evaluate the effects of the FSP on other programs or practices. Along the same lines of exploring “community connectedness,” consider the effects of the FSP on other programs and practices. For example, explore how the development of the FSP influences the development or transformation of other intensive case management programs outside of the FSP. Or examine programs pre-MHSA to see how clients in these programs are faring or how they have changed post-MHSA. Furthermore, study how FSP planning and implementation have fostered client and community participation in other MHSA-related activities.

- Assess levels of care. Many counties have experienced a lack of client “flow” through their systems. More specifically, some clients who are admitted into FSP programs remain in them long after they have achieved a significant level of recovery and no longer need the intensive level of care that an FSP delivers. To rectify such situations, consider evaluating the method of determining the FSP level of care that clients need and deciding when they qualify for a higher or lower level of care (e.g., standard outpatient care, wellness center, or client-run center). Evaluations of this nature could instigate organizational improvements leading to a better integrated system. FSP personnel might, for example, study whether clients being served are markedly different from each other within each level of care, and whether the level of care is appropriate for clients’ needs for services and supports. A separate study might track services across the levels to elucidate...
similarities and differences in service dosage and utilization. Another study might track the movement of clients among levels. These studies ultimately would inform the outcomes of programs and practices within and across levels of care.

- Examine unintended consequences. In many cases, program components have unintended consequences. Some clients of FSP services, for example, may experience a ceiling effect on employment. They may be unwilling to jeopardize financial assistance if employment compensation does not exceed the amount of financial assistance they are receiving. An evaluation that explores that and other deterrents could shed light on why employment outcomes are weaker than anticipated.

Administrators of FSP programs in smaller counties or counties with limited evaluation resources should prioritize the questions (as well as indicators and measures). Choosing the right questions is necessary to conduct an evaluation that yields useful information and attainable goals.

- Take into consideration economy of scale to develop evaluation questions that build upon existing evaluation efforts. If other evaluations are taking place, borrow ideas about evaluation questions, measures, and other elements. Some aspects of program implementation cut across multiple programs. For example, cultural competence is relevant to most if not all programs. Cultural competence may be very important to the FSP evaluation, but if other evaluations also address cultural competence, consider building upon that work by altering the questions (and study methods) to complement existing efforts. Moreover, if data on penetration rates are difficult to obtain (for example, the number of Spanish-speaking clients in a small county remains low during a program’s early stage of implementation), then evaluation questions about differential impact across target populations will be difficult to answer.
Implementation Strategies (cont’d)

- Determine the work that will be required to collect and analyze data in order to answer the evaluation questions. The data collection and analysis process may entail:
  - Running trials of reports by creating spreadsheets, turning them into graphs, and developing reporting structures in order to assess upfront the resources necessary to execute the reports.
  - Modifying the evaluation questions based on these trial runs.
  - Anticipating that mistakes might happen more frequently with limitations in staff resources and staff expertise.
  - Spending extra time early in the phase of developing evaluation questions, in order to determine the demands of answering each evaluation question. Doing so often is worthwhile in the long run for counties that are short on resources.

Evaluation Intended to Change Practice

<table>
<thead>
<tr>
<th>Examples of Evaluation Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Example 1</strong></td>
</tr>
<tr>
<td>The purpose of this evaluation is to explore the reasons why clients successfully graduate from an FSP program.</td>
</tr>
<tr>
<td><strong>Sample evaluation questions:</strong></td>
</tr>
<tr>
<td>1. How many clients are enrolled in the FSP program?</td>
</tr>
<tr>
<td>2. For what reasons do clients engage in the FSP program?</td>
</tr>
<tr>
<td>3. How many days do clients participate in the FSP program? How does the number of days for clients who discharge early differ from the number of days for clients who graduate?</td>
</tr>
<tr>
<td>4. What are the reasons for client exit or discharge?</td>
</tr>
<tr>
<td>5. What factors contribute to clients completing the FSP program?</td>
</tr>
</tbody>
</table>
## Implementation Strategies (cont’d)

### Example 2

The purpose of this evaluation is to explore the trajectory and time frame of client participation in an FSP program.

**Sample evaluation questions:**

1. What is the range and what is the average time* of client participation in the FSP program?
2. Do clients begin FSP services “ready” to fully participate in the program?
3. What client characteristics are associated with being “ready”?

*Time can be calculated in days, weeks, months, or years – depending on the typical time range and what information is most useful.*
Purpose

To assess the relationship between program activities and observed consequences of those activities.

Definition

Assessing effects, a type of evaluation appropriate for mature programs, can define which interventions were delivered to what proportion of the target population. This type of evaluation, which is designated a “summative” evaluation, is intended to gain knowledge that could be used for decisions about program adoption, continuation, expansion, or elimination.

Summative evaluations are designed to make a judgment about the worth of the program. Summative and formative evaluations can be performed separately or in conjunction. Neither evaluation has a prescribed timeline in which it should be done. From a development perspective, fluidity in determining when to perform a formative or summative evaluation helps to accommodate the developmental stage of a program. Personnel conducting an FSP program

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evaluation might engage, for example, in a formative evaluation throughout the program’s lifespan and may overlap with a summative evaluation at some point when the program administrators are ready to answer questions about program impact.

Examples of uses of evaluation for the purpose of assessing effects may include:

- Assessing skills development by FSP program clients.
- Determining which participants flourish in the FSP program.
- Assessing changes in service provider behavior over time.
- Comparing costs with benefits.
- Deciding where to allocate new resources.
- Assessing the level of success in accomplishing program objectives.
- Determining whether accountability requirements are fulfilled.
- Aggregating information from several evaluations to estimate outcome effects for similar kinds of programs.
- Gathering success stories.
Implementation Strategies

- Examine intended outcomes for the FSP. Avoid re-creating the wheel when identifying outcomes unless the FSP program has distinguishing elements linked to unique outcomes that are not typically identified in statewide guides. Use the work of the California Mental Health Planning Council in developing appropriate evaluation questions and identifying appropriate outcome indicators.

- Use a complementary paradigm of evaluating child, youth, and family FSP programs. The typical outcome considerations for children, youth, and family members in FSP programs encompass placement, living situation, permanency, education, health and mental health, and child and family functioning. View these outcomes for children within a paradigm of resiliency (versus recovery). For example, ask evaluation questions that reveal protective and risk factors for children, their caregivers, and the family as a whole. In evaluations of children’s programs, ask questions about program effects on their parents or caregivers (e.g., have they increased self-sufficiency?) because such results constitute an integral part of the program and the child’s life. For youth, look to the youth development literature on, for example, peer support and mentorship. Additionally, consider all these outcomes within a system of service delivery that involves the child welfare system, juvenile justice system, health providers, and educators.

- Build upon the work of others. Personnel from county-level programs throughout California have devised numerous questions for use in evaluating FSP programs. For example, information on the rate of education and employment (two important aspects of the recovery model) is being collected. Other questions ask about disparities in gender, race, or ethnicity that become apparent in outcomes of FSP programs. Furthermore, information about independent living is being gathered to assess the extent
to which an FSP is helping clients to secure housing and to move from more restrictive living situations (e.g., emergency housing) to less restrictive living situations (e.g., securing their own apartment).

- Examine unintended consequences. The previous topic on “changing practice” discussed how unintended consequences of a program can be analyzed as part of a formative evaluation. Unintended consequences also can be examined during summative evaluations. Using the example of employment, outcome information on employment rates is supported by process information on how clients perceive and act upon the ceiling effect of employment and its consequences for financial support. Process and outcome data can complement each other to provide a clearer picture of the effects and results of program operations.

- Use the logic model to generate the evaluation questions by which to assess program impact. A logic model that guides the process of deriving the evaluation questions helps determine the direction for the study design, which indicators to choose, how to measure those indicators, which tools or instruments to use, and how to analyze and interpret the findings.

The following table from the Planning Council’s report lists the individual client outcomes for child, youth and family, transition age youth, adults, and older adults.4

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### Individual Client Outcomes for Each Target Population

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Measurement Method</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child/Youth Outcomes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicator 1 – Living situation: homeless or shelter; justice system placement</td>
<td>FSP: Change over time</td>
<td>DCR</td>
</tr>
<tr>
<td>Indicator 2 – Education attendance: suspensions; expulsions</td>
<td>FSP: Change over time</td>
<td>DCR</td>
</tr>
<tr>
<td>Indicator 3 – Legal status: moved out of home; reunited</td>
<td>FSP: Change over time</td>
<td>DCR</td>
</tr>
<tr>
<td>Indicator 4 – Number of emergency room visits; physical health and mental health</td>
<td>FSP: Change over time</td>
<td>DCR</td>
</tr>
<tr>
<td>Indicator 5 – Parent or caretaker rating of improvement in child or youth functioning (coping when things go wrong, school, relations with friends and others, relations with family, handling daily life)</td>
<td>FSP: Point in time</td>
<td>YSS-F</td>
</tr>
<tr>
<td>Indicator 6 – Youth self rating of improvement in functioning (same as #5)</td>
<td>FSP: Point in time</td>
<td>YSS</td>
</tr>
<tr>
<td><strong>TAY Outcomes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicator 7 – Living situation: homeless or shelter; justice system placement; independent; number of moves; hospitalization</td>
<td>FSP: Change over time</td>
<td>DCR</td>
</tr>
<tr>
<td>Indicator 8 – Education or employment</td>
<td>FSP: Change over time</td>
<td>DCR</td>
</tr>
<tr>
<td>Indicator 9 – Number of arrests</td>
<td>FSP: Change over time</td>
<td></td>
</tr>
<tr>
<td>Indicator 10 – Number of emergency room visits; physical health and mental health</td>
<td>FSP: Change over time</td>
<td>DCR</td>
</tr>
</tbody>
</table>
# Implementation Strategies (cont’d)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Measurement Method</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator 11 – Self rating of improvement in functioning (same as #6 or #16, depending on age)</td>
<td>FSP Point in time</td>
<td>YSS or MHI-SIP</td>
</tr>
<tr>
<td>Adult Outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicator 12 – Living situation: homeless or shelter; justice system placement; independent; number of moves; hospitalization</td>
<td>FSP: Change over time</td>
<td>DCR</td>
</tr>
<tr>
<td>Indicator 13 – Employment</td>
<td>FSP: Change over time</td>
<td>DCR</td>
</tr>
<tr>
<td>Indicator 14 – Number of arrests</td>
<td>FSP: Change over time</td>
<td>DCR</td>
</tr>
<tr>
<td>Indicator 15 – Number of emergency room visits; physical health and mental health</td>
<td>FSP: Change over time</td>
<td>DCR</td>
</tr>
<tr>
<td>Indicator 16 – Self rating on improvement in functioning (symptoms, housing situation, school or work, social situations, relations with family, dealing with crises, control over life, dealing with problems)</td>
<td>FSP: Point in time</td>
<td>MHSIP</td>
</tr>
<tr>
<td>Older Adult Outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicator 17 – Living situation: homeless or shelter; number of moves; hospitalization</td>
<td>FSP: Change over time</td>
<td>DCR</td>
</tr>
<tr>
<td>Indicator 18 – Number of emergency room visits; physical health and mental health</td>
<td>FSP: Change over time</td>
<td>DCR</td>
</tr>
<tr>
<td>Indicator 19 – Activities of daily living</td>
<td>FSP: Change over time</td>
<td>DCR</td>
</tr>
<tr>
<td>Indicator 20 – Instrumental activities of daily living</td>
<td>FSP: Change over time</td>
<td>DCR</td>
</tr>
</tbody>
</table>
Implementation Strategies (cont’d)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Measurement Method</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator 21 – Self-rating on improvement in functioning (same as #16)</td>
<td>FSP: Point in time</td>
<td>MHSIP</td>
</tr>
</tbody>
</table>

Evaluation Purpose to Assess Effects

### Examples of Evaluation Questions

#### Example 1
The purpose of this evaluation is to examine the outcomes of an FSP program for older adults.

**Sample evaluation questions:**

1. To what extent did the living situation of clients change after enrollment in the FSP program?
2. Did the number of psychiatric hospitalizations increase or decrease after enrollment in the FSP program?
3. Did clients improve in daily living activities after enrollment in the FSP program?
4. Did the rates of employment or volunteer activity improve after enrollment in the FSP?

#### Example 2
The purpose of this evaluation is to examine whether stabilization of client outcomes can be achieved with less intensive FSP services.

**Sample evaluation questions:**

1. To what extent were client outcomes achieved?
2. How long, on average, are intensive FSP services required before clients can be moved to a lower level of care?
3. What percentages of clients need to return to intensive FSP services within six months after moving to a lower level of care?
4. What levels of client outcome(s) (e.g., residential setting, employment status, MORS score, LOCUS score) needs to be achieved to consider moving a client to less intensive services (e.g., standard clinic or wellness center)?
Affecting Participants

Purpose
To create a process for self-directed change.

Definition
Affecting participants refers to using the process of evaluation inquiry to affect participants in the inquiry. The logic and systematic reflection required of stakeholders who participate in an evaluation can be a catalyst for self-directed change and can occur at any stage of program development.
Implementation Strategies

Initiate an evaluation with the intent to generate a positive influence on stakeholders. For example, use evaluation to empower FSP program participants (e.g., increasing a client’s sense of control over program direction), to promote staff development (e.g., teaching the staff how to collect, analyze, and interpret evidence), to contribute to organizational growth (e.g., clarifying how the FSP program relates to the organization’s mission), or to facilitate social transportation (e.g., advancing a community’s struggle for self-determination).

Use these strategies to engage stakeholders in defining and refining evaluation questions by:

- Encouraging open sharing of interests and potential questions.
- Listening to stakeholders’ needs and interests.
- Sorting through and prioritizing questions with stakeholders.
- Clarifying questions so that they are measurable and meaningful (including culturally meaningful).
- Helping stakeholders to articulate the questions to be answered.
- Fostering stakeholders’ “ownership” of the evaluation.

Avoid mistakes in developing or narrowing the list of potential evaluation questions. Such mistakes may include:

- Deciding on the evaluation questions without stakeholder input.
- Addressing questions that stakeholders do not value.
- Eliminating questions only because they initially appear unanswerable.
- Monopolizing the evaluation.
- Assuming that the program is like all other programs.
Assigning evaluation with the explicit purpose of affecting participants can be a separate and explicit task. However, the intention of affecting participants typically is implicit and cuts across all types and purposes of evaluation. Evaluation can affect participants in the FSP evaluation process by:

- Reinforcing FSP intervention messages.
- Stimulating dialogue and raising awareness regarding mental health issues.
- Broadening consensus among MHSA stakeholders regarding FSP program goals.
- Teaching evaluation skills to the staff and other stakeholders.
- Increasing cultural proficiency through the exchange of cultural knowledge.
- Supporting organizational change and development.
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 88–91. This guide enables you to focus on the pertinent resources linked directly to each tool.

<table>
<thead>
<tr>
<th>Name of Tool</th>
<th>Resource Number(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gaining Insight</td>
<td>1,2,4,5</td>
</tr>
<tr>
<td>Changing Practice</td>
<td>6,7,15,16,17,18,19,20,21,22,23</td>
</tr>
<tr>
<td>Assessing Effects</td>
<td>2,3,8,9,10,11,12,14,24</td>
</tr>
<tr>
<td>Affecting Participants</td>
<td>13</td>
</tr>
</tbody>
</table>
Books


Data Collection Instruments


7. Gilmer, T. *The FSP Practices Scale*. University of California, San Diego. For a copy of the scale or for more information on the scale, contact Todd Gilmer at tgilmer@ucsd.edu or 858-534-7596.
✔ FSP Indicators


✔ Recovery Measures in Use in California


✔ Report

✔ Report Generator


✔ Resource Kit


✔ Tool Kits – FSP


✔ Tool Kits – FSP Cultural Relevance


✔ Website

Domain #4

Design and Data Collection

Evaluation designs are based on scientific research options and can be divided into three categories: experimental design, quasi-experimental design, and non-experimental (or observational) design. A design should be chosen to convey appropriate information to respond to stakeholders’ evaluation questions. Following completion of the design, data are collected to answer the evaluation questions while meeting the stakeholders’ standards for credibility.
Purpose

To obtain appropriate information based on stakeholders’ requirements.

Definition

*Designing an evaluation* is the method used to create a tool that will convey appropriate information to respond to stakeholders’ evaluation questions. Evaluations can be designed in any of three configurations: experimental designs; quasi-experimental designs; or non-experimental (or observational) designs.

1. **Experimental designs** randomly assign persons to either an intervention or a non-intervention group. Random assignment helps to ensure that the two groups are similar in their composition, with the exception that one group receives the intervention and the other receives either “business as usual” or no intervention at all. When the intervention is complete, differences between the two groups in the outcome of
interest are measured. If a difference in outcome is found, it likely is caused by the intervention. Experimental designs generally are considered the most “rigorous” approach but also are the most resource-intensive (i.e., expensive and difficult).

(2) **Quasi-experimental designs** are similar to experimental designs, except that persons are not randomly assigned to a group. This type of method is used when random assignment is not feasible. Instead, nonequivalent groups are compared (e.g., one group receiving the intervention versus those on a waiting list) or multiple waves of data are set up as a comparison (e.g., interrupted time series). The “Resources” segment at the end of this tool section contains an entry for an article that supports quasi-experimental designs over the “gold standard” of experimental design. That article promotes the use of existing data sets such as the Data Collection and Reporting [DCR] system for comparative studies that help evaluate effectiveness without costly experimental studies.

(3) **Non-experimental (or observational) designs** use comparisons within a group to explain unique features of its members (e.g., comparative case studies or cross-sectional surveys). They tend to be descriptive and attempt to illuminate differences, similarities, and processes within a group. Correlational studies are common non-experimental studies that sometimes are misunderstood as studies of causation.
Implementation Strategies

- Understand when to use each design:
  - *Experimental designs* are used when answering the question “Did my program cause this specific impact on participants?” Random assignment to groups is a required condition when implementing an experimental design.
  - *Quasi-experimental designs* are used when answering the question “How does my program compare to another program?”
  - *Non-experimental designs* are used when answering questions that are observational or descriptive in nature. Most FSP studies use non-experimental designs such as the one group pretest-posttest measuring the number of psychiatric hospitalizations within 12 months pre-FSP compared to the same measure within 12 months post-FSP. In this design, no comparison groups are used; only FSP participants are included in the study. These designs are common in evaluation studies. However, they are not particularly good for exploring cause-effect questions that examine the relationship between a program and its outcomes.

- Know the *levels of evidence* when selecting the study design in order to gauge the ranking of the design selections in the hierarchy of evidence.

The following table presents the rating system for evidence-based practices, based on the guidelines that major institutions, including the Institute of Medicine (http://www.iom.edu/) and the Substance Abuse and Mental Health Services Administration (http://www.samhsa.gov/), established for characterizing a practice as evidence-based.
<table>
<thead>
<tr>
<th>Rating</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-Support</td>
<td>1. No clinical or empirical evidence or theoretical basis indicates that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.</td>
</tr>
<tr>
<td></td>
<td>2. More than one rigorous randomized controlled trial has been conducted, using valid outcome measures, and has obtained consistent outcomes (positive effects with statistically significant results) in more than one setting and/or with more than one population.</td>
</tr>
<tr>
<td></td>
<td>3. The practice can be replicated.</td>
</tr>
<tr>
<td></td>
<td>4. Fidelity measures exist or can be developed from available information.</td>
</tr>
<tr>
<td>Supported</td>
<td>1. No clinical or empirical evidence or theoretical basis indicates that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.</td>
</tr>
<tr>
<td></td>
<td>2. At least one rigorous randomized controlled trial has been conducted, using valid outcome measures, and has identified positive effects with statistically significant results.</td>
</tr>
<tr>
<td></td>
<td>3. The practice can be replicated.</td>
</tr>
<tr>
<td></td>
<td>4. Fidelity measures exist or can be developed from available information.</td>
</tr>
<tr>
<td>Promising</td>
<td>1. No clinical or empirical evidence or theoretical basis indicates that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.</td>
</tr>
<tr>
<td></td>
<td>2. A less rigorous research and evaluation design or quasi-experimental design, using valid outcome measures and some form of control, has been conducted with evidence of positive effects.</td>
</tr>
<tr>
<td>Emerging</td>
<td>1. No clinical or empirical evidence or theoretical basis indicates that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.</td>
</tr>
<tr>
<td></td>
<td>2. The practice has sound theoretical rationale and has shown to be related to positive change through a minimum of a pre/post evaluation using valid outcome measures.</td>
</tr>
</tbody>
</table>
Implementation Strategies (cont’d)

- Consider both quantitative and qualitative methods to answer evaluation questions. Evaluations that mix methods are generally more effective because each method option has its own bias and limitations. Qualitative research is a method of inquiry for understanding a social or human problem defined by words (versus numbers for quantitative research) that describe detailed information about the problem. The following are examples of the different types of qualitative research:

  - **Phenomenology** – a form of qualitative research in which the researcher attempts to understand how one or more individuals experience a phenomenon. For example, a provider might interview 20 FSP clients and ask them to describe their experiences with the services they received.

  - **Ethnography** – the form of qualitative research that focuses on describing the culture of a group of people. Note that a *culture* constitutes the shared attitudes, values, norms, practices, language, and material things of a group of people. In an ethnographic study, an evaluator might, for example, decide to live in a Mohawk community and study how the culture defines and deals with mental illness.

  - **Case study research** – a form of qualitative research that is focused on producing a detailed account of one or more cases. A provider might study, for example, how a community of migrant workers mobilized to bring health and mental health services to their community.

  - **Grounded theory** – a qualitative approach to generating and developing a theory from data that the researcher collects. For example, one might collect data from foster youth who drop out of school, and develop a theory to explain why this phenomenon occurs.
Implementation Strategies (cont’d)

- *Historical research* – information about events that occurred in the past. For example, a provider might study the inception of public mental health services in the United States.

- Avoid packing a comprehensive evaluation into a simple design. Child, youth, and family FSP programs are complex, in part because they involve multiple service delivery systems. This means that the evaluation design of such an FSP program potentially would be multi-faceted – for example, utilizing administrative data from multiple departments, collecting primary data from clients, and conducting assessments by case managers and teachers. Capturing the diversity of age, ethnicity, presenting problems and strengths, service systems, and other characteristics requires different study designs, a lot of creativity, and resources.

- Be aware that the evaluation design and methods might need to be revised or modified during the course of an evaluation. For example, circumstances that make a particular approach credible and useful can change if, during the course of the evaluation, the purpose of the evaluation shifts from program improvement to program expansion with a new target population.
Identifying Indicators

Purpose

To be able to address the conditions that will be used to judge the FSP program.

Definition

Identifying indicators helps to establish criteria for measuring different aspects of the FSP program. Indicators are aspects of the program that can be examined to respond to the evaluation questions. Indicators translate general concepts about the program, its context, and its expected effects into specific measures that can be interpreted. They provide a basis for collecting evidence that is valid and reliable for the intended uses of the evaluation.
Implementation Strategies

- Identify indicators that can be defined and tracked for measuring program activities (process measures) and program effects (outcome measures).

Examples of indicators of program activities or process measures include:

- Program’s capacity to deliver services.
- Participation rate (i.e., entry into program).
- Access to care.
- Efficiency of resource use.
- Availability of service system supports.
- Client utilization of services within a program.

Examples of indicators of program effects or outcome measures include:

- Changes in participant behavior.
- Health or mental health status.
- Quality of life.
- Levels of client satisfaction.
- Reunification rates for children.
- Changes in living situation.
- Involvement with law enforcement personnel.

- Avoid defining too many indicators. While multiple indicators are needed for tracking program implementation and effects, inclusion of too many indicators can detract from the evaluation’s goals. Use the logic model to define the range of indicators leading from program activities to expected effects. For each step of the logic model, consider both quantitative and
Implementation Strategies (cont’d)

qualitative indicators. Relate indicators to the logic model to help detect small changes in performance. Doing so helps to reveal changes faster than relying on a single outcome as the only measure of performance. Using the logic model in this way also helps to clarify the lines of responsibility and accountability, because the measures are aligned with each step of the program strategy.

Choose indicators that are reliable and valid, or are measured with reliable and valid tests, instruments, or tools. “Reliability” refers to the consistency of measurement. For example, a reliable scale would consistently report the same weight if one measures one’s weight multiple times in a row. “Validity” refers to the extent to which something measures what it claims to measure. Using the same example above, a valid scale would report one’s correct or true weight. Reliability is a necessary but insufficient condition for validity; therefore, a valid test, instrument, or tool is reliable by definition, but a reliable test, instrument, or tool may not necessarily be valid. Using the same example above, a valid scale would consistently report one’s correct weight, but a scale that is only reliable and not valid might consistently report one’s incorrect weight. This distinction is important for evaluation and research as a whole. The credibility of evidence lies heavily on the validity of measures. Measures that are not valid might raise questions regarding the integrity of the evaluation.

Establish a common definition for indicators with service partners. For example, for the outcome of a living situation, what is the definition of a single-room occupancy (SRO) unit or an apartment? Include clients and other stakeholders in defining the indicators.
Beware of making key program decisions (or recommending policy or practice changes) based on tracking indicators. Measuring program performance by tracking indicators is only one part of an evaluation; it does not constitute a complete evaluation process to reach fully justified conclusions. For example, an indicator such as low employment rates might be assumed to reflect a failing program when, in reality, the indicator is influenced by changing conditions that are beyond the program’s control.
Selecting the Sources of Evidence

Purpose
To identify the sources of evidence that provide information to address the evaluation questions.

Definition
Selecting the sources of evidence in an evaluation involves identifying and including the persons, documents, and/or observations that offer information to respond to the evaluation questions. Potentially multiple sources of evidence may exist for each indicator to be measured.
Implementation Strategies

- Select multiple sources of evidence as a way to include different perspectives of the program and therefore to enhance the evaluation’s credibility. For example, program managers and line staff members might have differing perspectives about organizational barriers that impede delivery of FSP services. Clients’ perspectives about program impact may differ from that of their case managers. Not all clients value an outcome in the same way. For example, cultural differences may lead some parents to place greater value on employment of their TAY than on their attendance at school. Additionally, cultures may have different views on the appropriate age for emancipation and independence. Including a variety of perspectives provides a more comprehensive view of the program.

- Use existing data as a way to reduce or eliminate the need to collect new data for evaluation; doing so can be beneficial for smaller counties in particular. Explore existing data sources such as administrative data, school data, and health-related data for local jurisdictions (e.g., the Los Angeles County Health Survey). Do not tailor evaluation questions toward existing data simply because the data are readily available, however. Evaluation questions should drive data collection and not the inverse.

- Be clear about the selection criteria when choosing sources of evidence. Transparency is important for establishing credibility. Clearly stating the criteria allows evaluation users and other stakeholders to interpret the evidence accurately and to assess if the evidence might be biased.

- Integrate quantitative and qualitative information to potentially increase the chances that the evidence will be balanced, thus meeting the expectations of diverse stakeholders. Quantitative information comes in the form of numbers, whereas qualitative information comes typically in the

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6. 2007 Los Angeles County Health Survey, conducted by Los Angeles County Department of Public Health, Health Assessment Unit. Retrieved from http://publichealth.lacounty.gov/ha/hasurveyintro.htm
Implementation Strategies (cont’d)

form of narratives. For example, quantitative information on employment outcomes might be recorded by case managers during their monthly contact with clients. This might be reported as the proportion of clients who found part-time or full-time employment (within a 12-month period of participating in an FSP program) after being unemployed. Qualitative information on the same outcome might include interviews with clients about their employment experience, highlighting difficulties they may have encountered in seeking and retaining employment, reasons for seeking part-time or full-time employment, the kinds of supports that are crucial to the success of clients in their employment experience, and feelings associated with being employed, un-employed, or under-employed.

Seek data directly from the service delivery systems that collect the data. Doing so is especially relevant for child, youth, and family FSP programs that rely on allied service delivery systems to furnish services to children, youth, and their families. Departments of mental health or behavioral health may not have access to education and juvenile justice data, for example. Furthermore, the data they do have may not be accurate. Sharing information within the rules of the Health Insurance Portability and Accountability Act (HIPAA) ensures greater accuracy, which in turn enhances the evaluation’s credibility and usefulness.
Ensuring Quality of Evidence

Purpose

To meet the stakeholders’ threshold for credibility, and to ensure a level of quality of evidence that meets the stakeholders’ threshold for credibility.

Definition

Involving stakeholders in the evaluation process creates a method for ensuring quality of evidence. The word *quality* in this context refers to the appropriateness and integrity of information used in an evaluation. High-quality data are representative of what they are intended to measure and definitively indicate their intended use. Clearly defining indicators for the evaluation makes the collection of quality data easier. Other factors presented in this tool also affect quality.
Implementation Strategies

- Select and/or design high-quality instruments. (Refer to the “Identifying Indicators” tool for more information on reliability and validity.)
  
  - Choose measures that already have been tested for reliability or validity (also referred to as “psychometric properties”). This is especially important for smaller counties or counties with limited evaluation resources. Developing one’s own instrument and testing it for its psychometric properties requires time and expertise. If a valid instrument is not available for the specific measure or indicator of interest to the FSP service evaluation, consider partnering with a local university to assist with developing and testing the instrument. Be aware that if an existing, valid instrument is adapted, modifications – including language translations – could alter the validity of the instrument.

  - Carefully consider the selection, adaptation, or development of instruments for use with ethnic minorities. Unless the instrument was developed specifically for an ethnic group, chances are high that it has not been tested across various ethnic groups. The concepts and constructs being measured by an instrument (e.g., recovery) often are culturally specific. Therefore, an instrument may not yield the same results across ethnic groups despite consistency of all other characteristics among those who were administered the same instrument.

- Consider appropriate data collection procedures. (Refer to the “Considering the Logistics of Data Collection” tool.) Think through data collection procedures before committing to a data source. Program administrators who are trying to maximize limited resources in low-population counties should carefully contemplate data collection procedures in order to
avoid overcommitting resources to evaluation. Even existing data sources require data collection procedures that may be more involved than other data sources that require primary data collection. For example, accessing administrative data from another county department might require additional memorandums of understanding (MOUs) and Institutional Review Board (IRB) approval. Data collection procedures for data sources other than program staff also require careful planning. For example, focus groups with clients require a detailed protocol, incentives for participation, consideration of transportation and child care needs, food, consent to participate (possibly through an IRB), and more.

- Train data collectors to ensure quality. Some data collection methods require more training than others. Observations may require trained observers to detect, for instance, certain behaviors, moods, and environmental factors. Data collectors administering a paper-and-pencil survey might require less training if their role is limited to explaining the survey and ensuring its completion. Take into consideration all training needs before starting data collection. Aim for consistency in data collection among all data collectors.

- Select multiple sources of evidence. (Refer to the “Selecting the Sources of Evidence” tool.) The DCR system may not contain all the data elements of interest to evaluation stakeholders. Utilize alternative sources of data to answer evaluation questions that are specific to an age group, an ethnic group, or a cultural group. For example, rely on case notes to study differences and similarities in treatment goals across ethnic groups. Moreover, consider tracking additional information that is viewed as crucial to stakeholders. For instance, track and report on client grievances as one measure of whether an agency is doing clients harm.
Implementation Strategies (cont’d)

- Code the data. Coding prepares quantitative and qualitative data for further in-depth analysis. For quantitative data, coding is typically the assignment of a numeric value to a variable. For example, one might code gender by assigning a value of “1” to females and “2” to males. This enables statistical analysis of data on gender (along with other variables). For qualitative data, coding is a process for categorizing data. Numerous qualitative approaches to coding data have been devised.

- Manage the data. Before beginning, identify who should be responsible for the quality and management of data. Determine the roles of the county and service providers in managing the data and ensuring their quality. Consider requiring providers to assign agency-specific staff members the responsibility of managing the data.

- Perform routine error checking. Clean the data regularly and early in the data collection process to ensure that the data being collected are valid with respect to completeness (i.e., no missing data), truthfulness of the data (e.g., data are not being fabricated), and timeliness of data (i.e., data are collected and entered into a database within a reasonable amount of time for punctual reporting). Use strategies implemented by numerous counties for cleaning data by:
  - Applying a “tickler” system to track and clean data. This system flags data that are outliers.
  - Considering regularly sharing with an FSP service provider a single data element (e.g., living situation) that can be reviewed for suspicious data. Focusing on one data element or a few data elements at a time makes the data cleaning task more manageable.
Implementation Strategies (cont’d)

- Developing a system for sharing reports with FSP service providers.
- Generating monthly reports on key event tracking (KET) data for individual clients as a way to verify the data that providers submitted.
- Developing a mechanism for FSP service providers to submit data directly to the DCR. An accompanying mechanism must be in place for the county to draw down the DCR data submitted by their providers.
- Verifying a cohort of pre-enrollment data (e.g., psychiatric hospitalization). For example, some small counties may have this capability given the relatively small number of FSP clients served. This is one advantage of small sample sizes; individual cases and their respective data can be monitored with greater detail.
- Developing criteria for determining when data should be questioned or considered “suspicious.” For example, the FSP key event data require changes whenever a significant residential event, such as a hospitalization, occurs in the life of a client. Most hospitalizations last fewer than 10 days; patient discharge is another key event that must be recorded to delineate post-hospital residential status. Therefore, an analyst might reasonably scrutinize all hospitalizations of more than 15 days to identify possible failures to enter the new residential key event change.

Be practical in striving for quality data. All data have limitations; therefore, trying to meet – but not necessarily exceed – the stakeholders’ threshold for credibility is practical. Engaging stakeholders in the evaluation process helps determine that threshold. Inevitable trade-offs (e.g., breadth versus depth) should be negotiated among stakeholders.
Purpose
To determine the right amount of evidence to address the evaluation questions.

Definition
Quantity refers to the amount of evidence gathered in an evaluation. Quantity affects the potential confidence level or precision of the evaluation’s conclusions. Determining the quantity of evidence is important; identification of a sufficient amount of data is a means of avoiding unnecessary or excessive data collection.
Implementation Strategies

- Be sure to have a clear and anticipated use for all evidence collected. That determination helps minimize the burden placed on participants or respondents. This strategy is critically important especially for small counties or counties with limited resources for evaluation. The principle of placing minimal burden on participants also applies to the staff.

- Estimate in advance the amount of information and the time to gather the information required. Determine how many persons must furnish information to adequately respond to the evaluation questions. The burden on persons to provide and collect information always should approach the minimum needed. If the evaluation process is evolving, establish criteria by which to decide when to stop collecting data.

- Take a sample that is representative of the group. If the group is large (e.g., all FSP clients since a program’s inception for an entire county) and one wants to conduct interviews, do not try to include everyone in the group.
Considering the Logistics of Data Collection

Purpose
To plan the process of collecting data.

Definition
*Considering the logistics of data collection* means to anticipate the procedures, timing, and space (or physical infrastructure) for gathering and handling evidence. Each technique selected for gathering evidence (e.g., written survey, case study, testimonials) must be suited to the source(s), analysis plan, and strategy for communicating findings.
Implementation Strategies

- Consider how culture influences decisions about acceptable ways of asking questions and collecting information. For example, in Native American culture, the collective outcome typically holds greater value than the individual outcome. Among Asian Americans, psychosomatic troubles commonly are manifested and discussed as physical problems.

- Consider how culture influences decisions about who would be perceived as an appropriate person to present questions when gathering information. For example, asking an African American woman to facilitate a focus group for African American women may be more appropriate than assigning someone who is not perceived to represent the community with which the target population most identifies.

- Align the procedures for gathering evidence in an evaluation with the cultural conditions in each FSP setting to ensure that the privacy and confidentiality of the information and sources are protected.

- Ensure that the existing technology is adequate to support data collection and reporting.

- Include in the evaluation budget any ancillary data collection expenditures such as food, incentives (or monetary compensation), transportation, and child care, particularly for clients and their families.

- Set a realistic time frame for data collection. Evaluations take time. Evaluations that involve stakeholders in the evaluation process take even more time. Allocate a time buffer within the evaluation time frame, and manage time expectations with stakeholders early in the evaluation process.
Implementation Strategies (cont’d)

<table>
<thead>
<tr>
<th>Selected Techniques for Gathering Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Written survey (e.g. handout, telephone, fax, mail, e-mail, or Internet).</td>
</tr>
<tr>
<td>• Personal interview (e.g. individual or group; structured, semi-structured, or conversational).</td>
</tr>
<tr>
<td>• Observation.</td>
</tr>
<tr>
<td>• Document analysis.</td>
</tr>
<tr>
<td>• Case study.</td>
</tr>
<tr>
<td>• Group assessment (e.g. brainstorming or nominal group – i.e., a structured group process conducted to elicit and rank priorities, set goals, or identify problems).</td>
</tr>
<tr>
<td>• Role play or other dramatization.</td>
</tr>
<tr>
<td>• Expert or peer review.</td>
</tr>
<tr>
<td>• Portfolio review.</td>
</tr>
<tr>
<td>• Testimonials.</td>
</tr>
<tr>
<td>• Semantic differentials, paired comparisons, or similarity or dissimilarity tests.</td>
</tr>
<tr>
<td>• Hypothetical scenarios.</td>
</tr>
<tr>
<td>• Storytelling.</td>
</tr>
<tr>
<td>• Geographical mapping.</td>
</tr>
<tr>
<td>• Concept mapping to describe ideas about a topic in pictorial form.</td>
</tr>
<tr>
<td>• Pile sorting – a technique that allows respondents to freely categorize items, revealing how they perceive the structure of a domain.</td>
</tr>
<tr>
<td>• Free-listing – a technique to elicit a complete list of all items in a cultural domain.</td>
</tr>
<tr>
<td>• Social network diagramming.</td>
</tr>
<tr>
<td>• Simulation or modeling.</td>
</tr>
<tr>
<td>• Debriefing sessions.</td>
</tr>
<tr>
<td>• Cost accounting.</td>
</tr>
<tr>
<td>• Photography, drawing, art, or videography.</td>
</tr>
<tr>
<td>• Diaries or journals.</td>
</tr>
<tr>
<td>• Logs, activity forms, or registries.</td>
</tr>
</tbody>
</table>
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 117–120. This guide enables you to focus on the pertinent resources linked directly to each tool.

<table>
<thead>
<tr>
<th>Name of Tool</th>
<th>Resource Number(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Designing an Evaluation</td>
<td>1,4,5,7,11,13,22</td>
</tr>
<tr>
<td>Identifying Indicators</td>
<td>2,6,7,13,16</td>
</tr>
<tr>
<td>Selecting the Sources of Evidence</td>
<td>4,5,7</td>
</tr>
<tr>
<td>Ensuring Quality of Evidence</td>
<td>3,8,10,15,17,18,19,20,21</td>
</tr>
<tr>
<td>Determining Quantity of Evidence</td>
<td>13</td>
</tr>
<tr>
<td>Considering the Logistics of Data Collection</td>
<td>9,12,13,14</td>
</tr>
</tbody>
</table>
✔ Articles


✔ Books


✓ County Report Using DCR Data

FSP Indicator


Technical Assistance

As part of the Program Improvement Projects (PIP), counties can develop one non-clinical PIP. This is an opportunity to receive technical assistance on data, including an assessment of data system capabilities (referred to as “Information Capabilities Assessment”), and the best practices of counties and agencies in ensuring the accuracy of their DCR data.

Validated Instruments

17. **ACT FIDELITY SCALE:**

A modified scale based on the Dartmouth Assertive Community Treatment Scale (DACTS). Retrieved from [http://www.ncebpcenter.org/pdfs/ACTFidelityScale.pdf](http://www.ncebpcenter.org/pdfs/ACTFidelityScale.pdf)

18. **FSP PRACTICES SCALE:**

Gilmer, T. *The FSP Practices Scale*. University of California San Diego. For a copy of the scale or for more information on the scale, contact Todd Gilmer at tgilmer@ucsd.edu or 858-534-7596.

19. **LOCUS – Level of Care Utilization System:**

20. **MORS – Milestones of Recovery:**


✔️ **Website**

Evaluative conclusions are based on evidence that is collected and analyzed; therefore, the conclusions must be justified and judged against agreed-upon standards set by the stakeholders. Common steps to justifying conclusions include: (1) examining the findings against agreed-upon standards; (2) interpreting or giving meaning to the findings; (3) judging a program or performance or making claims of merit, worth, or significance; and (4) recommending actions.
Preparing for Data Analysis

Purpose

To prepare for conducting data analysis to answer evaluation questions.

Description

Preparing for data analysis involves more than organizing the data and deciding on the analytic technique. Because data analysis requires technical expertise and (usually) computer software, gathering the resources for these requirements is a critically important step in the data analysis process.
Implementation Strategies

Prepare for data analysis by creating a matrix that identifies all the evaluation questions and the data available to answer those questions. This matrix already should reflect the analyses that are priorities for the evaluation (e.g., if following a logic model); however, if further prioritizing is necessary, consider these strategies by:

- Focusing the analysis on prioritized indicators for the five major outcomes of FSP captured in the Data Collection and Reporting (DCR) system: reducing homelessness, reducing incarceration, reducing psychiatric hospitalization, improving education, and improving employment.
- Letting the performance indicators for evaluating the mental health system guide decisions on prioritizing data analysis, as well as decisions on data analysis and reporting. (See the California Mental Health Planning Council report, listed in the “Resources” segment.)
- Determining the priority “groups” for analyzing disparities in access and outcomes. For example, if the FSP program targets adults in a multi-ethnic community, the analysis should place high priority on examination of data relevant to access and outcomes across ethnic groups. If the FSP program is a child and youth program, the analysis should place high priority on examination of outcomes across age groups (e.g., 0–5 years, 6–12 years, or 13–18 years).

Partner with service providers to analyze the data. Counties and providers can use each other as resources for data analysis; two or more providers likewise can exchange information. Partners in such an arrangement can use online forums and discussion boards as a way to communicate and
Implementation Strategies (cont’d)

collaboratively learn the different ways to analyze data. Partnering early in the data analysis process ensures greater uniformity in data preparation (e.g., coding data), analysis techniques (e.g., statistical tests), data interpretation, and reporting.

- Partner with other county departments or community-based partners such as faculty in local universities to assist with data analysis. Doing so is especially helpful for small counties or counties that have limited evaluation resources and lack the internal capacity for ongoing technical support in data analysis.

- Include computer software in the evaluation budget, and purchase software early to become acquainted with its capabilities. A common statistical software package for quantitative data analysis is the Statistical Package for the Social Sciences (SPSS). If the budget does not allow for the purchase of statistical software, consider downloading free statistical software. Most statistical freeware has the capability to conduct the types of analyses that are of interest to FSP evaluations. Many counties and community-based service providers have the software program Access, which could be useful for viewing DCR data.

- Determine all the units of analysis before conducting data analysis. That preparation is especially important for child, youth, and family FSP programs that involve not only the child or youth unit but also the family unit (including siblings, parents, grandparents, and kin within that unit), the program unit (i.e., partner programs or agencies), and the system unit (i.e., allied service delivery systems such as child welfare, juvenile probation, health, and education). Choosing multiple units of analysis ultimately has implications for analysis. For example, if the child or youth, family and system units are selected, each unit may have its own data source. If the outcome of education is analyzed across the units, school attendance of
Implementation Strategies (cont’d)

the child might be child-level data; a retrospective assessment of school attendance and/or perception of school improvement (provided by a parent) might be part of the family-level data; and the educational system’s response (provided by teachers) to improving education for the target population might be among the system-level data. These various data sources – whether they are quantitative or qualitative – have implications for the types of data analysis that can be conducted.

- Break data down into the units that will be needed to answer the research question. For example, if a provider has calendar dates and needs to know on which days of the week the participants visited a wellness center, this information must be captured separately as another unit of data. This level of detail is necessary to answer research questions that call for a high degree of specificity.
Conducting Quantitative Data Analysis

Purpose
To be able to provide appropriate data findings.

Definition
The process of conducting quantitative data analysis involves preparation of the data with a basic understanding of why, when, and how an analytic technique is used. Computers and computer software can perform data analysis functions efficiently.
Implementation Strategies

For preparation and analysis of quantitative data, consider the following strategies:

- **Code data.** To process the data, computers must access it in a compatible format; numerical coding is the best approach. Assignment of a numerical value to an answer option is a basic form of coding. For instance, when information on race is collected, each racial group is assigned a numeric value. Coding also is useful for confining information to a limited set of attributes. For example, if information on ethnicity encompasses 30 ethnic groups, analysis can be simplified by consolidation into seven major racial groups, with allocation of each ethnicity within one of those seven numerically coded racial groups.

- **Construct a codebook.** A codebook is a document that lists all the data elements that have been coded into a numerical value, which is typically entered into the computer or is coded as part of the computer software program. A codebook might look something like this:

<table>
<thead>
<tr>
<th>Variable or Data Element</th>
<th>Code or Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>1 – Male</td>
</tr>
<tr>
<td></td>
<td>2 – Female</td>
</tr>
<tr>
<td></td>
<td>0 – Unknown</td>
</tr>
<tr>
<td>Age</td>
<td>(Enter raw number)</td>
</tr>
<tr>
<td>Employment status at intake</td>
<td>1 – Not employed (and not looking for employment)</td>
</tr>
<tr>
<td></td>
<td>2 – Not employed (and looking for employment)</td>
</tr>
<tr>
<td></td>
<td>3 – Employed part-time</td>
</tr>
<tr>
<td></td>
<td>4 – Employed full-time</td>
</tr>
</tbody>
</table>

- **Clean the data.** When data are entered into a computer software program, some errors are inevitable. A small data set can be “cleaned” by a visual scan. For example, in the gender segment containing only three possible
Implementation Strategies (cont’d)

codes – e.g., 0, 1, and 2 – the presence of a “5” in the data would be erroneous. Visual scans are inefficient and prone to error, however, for large data sets. Rather, conducting a frequency count of each data element would reveal codes that are not assigned to the data element. Using the same example of gender, a frequency distribution that shows 200 females (code 1), 250 males (code 2), three unknowns (code 0), and one code 5 value would indicate that the value of 5 is an error. (More information on frequency distribution appears further within this tool.)

- Determine the level of measurement. Definitions of the levels of measurement usually are presented when the topic of measurement is discussed, but they are important to note here because the level of measurement of a variable partly determines what type of analysis can or cannot be conducted. Levels of measurement can be classified in four groups:

  - **Nominal variables** have no quantitative meaning. If female is coded “1” and male is coded “2,” considering male to be “more” or “greater” than female would not be appropriate because these codes are for naming (nominal) purposes only.

  - **Ordinal variables** can be logically rank-ordered. For example, if FSP clients rate service quality on an ordinal scale with the categories excellent, good, fair, or poor, the associated codes might be 4, 3, 2, and 1 respectively. Unlike nominal measurement, these ordinal codes have some quantitative meaning; 4 represents a higher rating than 3, and so on. However, although these codes represent some order, they do not represent a precise quantity of something. Therefore, we do not know the precise difference between them.
Implementation Strategies (cont’d)

- *Interval measures* have meaningful standard intervals, but the number zero is arbitrarily defined in interval measures and does not mean the complete absence of something. For example, zero in the Celsius scale is defined as the point at which water freezes. Similarly, someone who scores a zero on an IQ test could not be regarded as devoid of intelligence.

- *Ratio measures* have a true zero point. Examples of ratio measures include age, length of residence, number of times married, and number of hospitalizations.

### Determine the sample size

Using the techniques of *statistical power* and *sample size estimation*, decide if the sample size may be too high or too low. The primary goals of these techniques are to decide how large a sample is needed to enable statistical judgments that are accurate and reliable, and to determine the likelihood of the statistical test to detect effects of a given sample size. The following table provides some guidelines for calculating the sample size.

<table>
<thead>
<tr>
<th><strong>Determination of Valid Sample Sizes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Margin of error</strong></td>
</tr>
</tbody>
</table>

---

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### Determination of Valid Sample Sizes

<table>
<thead>
<tr>
<th>Confidence level</th>
<th>Standard is 95%</th>
<th>The confidence level indicates the amount of uncertainty that is considered tolerable. With a confidence level of 95%, there is a 5% margin of error. Suppose that a poll showed that 75% of voters favored a legislation, and that this estimate had a margin of error of plus or minus 5%. This means that there is a 95% chance that between 70% and 80% would vote for the legislation to pass (75% plus or minus 5%). Conversely, there is a 5% chance that fewer than 70% or more than 80% would vote for the legislation. A higher confidence level requires a larger sample size.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Size</td>
<td>Tabled census</td>
<td>What is the size of the population from which to choose a random sample? The sample size does not change much for populations larger than 20,000.</td>
</tr>
<tr>
<td>Response distribution</td>
<td>Standard if population is unknown = 50%</td>
<td>For each question, what are the expectations for the results? If the sample is skewed highly to one end, the population probably is, too. If the skewing tendency is unknown, use 50% to estimate a sufficiently large sample size.</td>
</tr>
<tr>
<td>Tabled valid sample size</td>
<td>Tabled valid sample</td>
<td>The valid sample size is the minimum recommended size of the survey. A survey of a sample of this many people, all of whom respond, is likely to be more accurate than a survey of a large sample that returns a small percentage of responses.</td>
</tr>
</tbody>
</table>

- Understand descriptive statistics, a method for reduction of data and presentation of quantitative descriptions in a manageable form. Descriptive statistics can be prepared using many techniques. Within the context of this Tool Kit, three basic techniques — *univariate analysis*, *bivariate analysis* and *multivariate analysis* — are appropriate to consider.

  - *Univariate analysis* is the examination of the distribution of cases one variable at a time. The most basic way to present univariate data is to report all individual cases. That, however, is not a manageable format.
A provider could instead report the frequency distribution of grouped data. Recall the previously cited example of gender identification; tabulating the frequency distribution of gender in the sample would generate a count of the subtotal of females and males. Another way to present this information is to use percentages. For example, within a total sample of 500 cases, 40 percent are females and 60 percent are males.

Yet another way to present data is to report averages (or measures of central tendency) in the form of the “mode” (the most frequent attribute), “arithmetic mean,” or “median” (the middle attribute). For example, if analyzing age for a child, youth, and family FSP program, the mode would be the most common age in the sample (e.g., 7 years); the mean would be the result of adding each age representing each child, and then dividing that sum by the total number of children in the analysis (e.g., 9 years); and the median (e.g., 8 years) would be the threshold at which half of the subjects in the sample are older and half are younger.

Not all data can be presented as averages. For example, gender is a nominal variable; therefore, it does not make sense to analyze gender as a mean. Age is a ratio variable and can be analyzed to present averages. Other variables that are appropriate for this type of analysis include number of psychiatric hospitalizations, scores on a depression scale, and length of incarceration in days, weeks, months, or years.

- **Bivariate analysis** is the examination of the distribution of cases on two variables at a time. Frequency distributions, percentages, and averages are calculated in bivariate analysis similarly to the univariate analysis.
method. Suppose, for example, that a provider wanted to know how many adult male and female clients were ever incarcerated before FSP participation. Depending on the level of measurement of the data, the findings can be presented in the following ways:

<table>
<thead>
<tr>
<th>Example of Frequency Distribution and Percentage for Two Variables at a Time</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Female (sample size = 200)</strong></td>
</tr>
<tr>
<td><strong>Ever incarcerated</strong></td>
</tr>
<tr>
<td><strong>Never incarcerated</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Example of Means for Two Variables at a Time</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Female (sample size = 200)</strong></td>
</tr>
<tr>
<td><strong>Total number of incarcerations prior to FSP participation</strong></td>
</tr>
</tbody>
</table>

- *Multivariate analysis* involves presenting more complicated subgroup descriptions that follow the same steps as described for bivariate analysis. Using the same example, the provider still wants to know how many adult male and female clients were ever incarcerated before FSP participation; however, the provider wants to know the distribution by age group. Again, depending on the level of measurement of the data, findings can be presented in several ways:

<table>
<thead>
<tr>
<th>Example of Frequency Distribution and Percentage for Three Variables at a Time</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Under 30</strong></td>
</tr>
<tr>
<td><strong>Female</strong></td>
</tr>
<tr>
<td><strong>Ever incarcerated</strong></td>
</tr>
<tr>
<td><strong>Never incarcerated</strong></td>
</tr>
<tr>
<td><strong>Sample size</strong></td>
</tr>
</tbody>
</table>
Use inferential statistics. Describing the sample is an important first step in presenting the evaluation findings. However, to make assertions about the larger population that the sample represents – or to explain the causal processes of the relationships observed in the data – statistical techniques must be used for making such inferences. These techniques are called inferential statistics. The logical bases for inferential statistics are too lengthy to cover in this Tool Kit. Therefore, this Tool Kit will focus on only a few statistical analyses that are useful in analyzing common questions about changes in FSP outcomes. Many inferential statistics details are critically important to consider not only when conducting the analysis but also in reporting the findings. Failure to fully understand the technique can easily lead to introduction of improper assumptions, resulting in skewed or inaccurate findings. Therefore, conclusions based on inferential statistics should be made with extreme caution. The information presented on these techniques in this Tool Kit is primarily intended to describe the types of analyses that are available to answer specific evaluation questions. These techniques are presented in the “Applying Statistical Techniques to FSP Evaluations” tool.
Applying Statistical Techniques to FSP Evaluations

Purpose

To use appropriate statistical tests to answer evaluation questions.

Definition

Applying statistical techniques to FSP evaluations in a proper manner can yield effective results. Many statistical tests for analyzing quantitative data are available. Some tests are commonly applied in social science research, including evaluations of mental health interventions. Examples of the various statistical techniques are described after the “implementation strategies” segment of this tool.
Implementation Strategies

- Select the appropriate tests of statistical significance. Tests or techniques that are useful for analyzing FSP evaluation data include:
  
  - **Parametric tests**, which assume that at least one of the variables being studied has an interval or ratio level of measurement, that the sampling distribution is normal for the relevant parameters of those variables, and that the different groups being compared have been randomly selected and are independent of one another. Two common parametric tests are the *t-test* and *analysis of variance* (ANOVA).
  
  - **Nonparametric tests**, which are used when not all of the assumptions of parametric tests can be met. Most of these techniques do not require an interval or ratio level of measurement, and can be used with nominal or ordinal data that are not distributed normally. The most common nonparametric test is a *chi-square test*. Small counties that have comparatively few FSP clients may find nonparametric tests practical because they can be used with sample sizes of fewer than 100 subjects.

- Annualize data for a period of less than a year by projecting calculations to represent a 12-month period. This technique, which is common in economic forecasting (e.g., estimating the annual rate of return on an investment), is useful for estimating numbers (usually for post-data or data collected from the start of FSP participation) for a cohort of participants with varying tenure in the program. For example, if data on psychiatric hospitalizations exist for only one quarter for the entire cohort of participants, the data can be annualized to represent the entire year for that cohort. The annualized numbers, however, are not true values; therefore, make certain to explain in reports and to stakeholders whether findings are based on annualized data.
Implementation Strategies (cont’d)

- Compare data from multiple informants. The “Preparing for Data Analysis” tool discussed units of analysis. Suppose that FSP program personnel wish to apply a statistical test to analyze data derived from multiple sources or informants. The available data include statistics on school attendance; a child or youth level indicator of educational outcome; and data on the parents’ perception of their children’s improvements in school, including attendance and other parameters. The school attendance data – or days present in school per academic year – is ratio data. The parent perception data, which is collected through a survey, is ordinal data (compiled from selections of either “strongly agree,” “agree,” “neutral,” “disagree,” and “strongly disagree”). An ANOVA test is useful to examine the relationship between the two variables. The results might reflect a statistically significant difference in school attendance between the five ratings. For example, children whose parents indicated that they “strongly agree” their child is improving in school might have greater attendance on average. Conversely, children whose parents indicated that they “strongly disagree” that their child is improving in school might have lower attendance on average. The result could reveal a statistically significant difference in school attendance between the five ratings, and could indicate that children whose parents “strongly agree” that their child is improving in school correlate on average to more consistent attendance in school.

- Examine multiple outcomes simultaneously. Certain statistical methods can examine multiple outcomes all together using “multivariate statistics.” A multivariate analysis of variance (MANOVA), for example, can test the effect of two levels of case management intensity on client satisfaction and on the number of days in psychiatric hospitalization. Other examples of multivariate analyses include structural equation modeling (SEM) and multilevel modeling. Explanation of these tests is beyond the scope of this Tool Kit. A provider partner that seeks to run these types of analyses but lacks internal resources may benefit from collaboration with local university researchers. Finally, note that these tests do not substitute for a proper study design that warrants conclusions about causality.
### Examples of How to Use a T-Test

This table describes two types of t-tests.

**Independent samples t-test** enables testing the arithmetic mean difference of one variable between two attributes. Suppose a provider wants to determine if a statistically significant difference exists between females and males (two attributes, nominal level of measurement) in the number of incarcerations (one variable, ratio measure) within 12 months of participating in an FSP program. This question assumes that the provider has data on gender and on incarcerations for one year post-participation. A statistical software program such as SPSS would calculate the mean difference between females and males in the number of incarcerations, and as part of the t-test, would indicate whether this difference is statistically significant. In this context, a finding is considered “significant” if its probability of occurring due to chance is at or below a cutoff point that the provider can select in advance. The typical cut-off point is .05, which signifies that a relationship is regarded statistically significant if it occurs due to chance no more than 5 times out of 100 randomized trials. If the t-test results indicate significance at .01, the provider might feel more confident that the differences observed between females and males are not due to chance, but rather that the results reflect a true relationship between gender and incarcerations. The provider might graphically present the findings in this way:

![Graph showing average number of incarcerations 12 months post-enrollment for females and males.]

The following is an example of a table that presents the typical information reported for a t-test. The p-value indicates whether or not the finding was statistically significant, based on the predetermined cutoff. In this example, the p-value is less than .05; therefore, the provider would present the difference as statistically significant. The primary purpose of this analysis is to describe gender differences in this outcome. Unless the design of the evaluation warrants making statements of causality (e.g., the FSP program was more effective for females than males), the conclusion should be descriptive only. In this case, the provider is reporting differential outcomes in incarceration rates; this analysis alone does not explain the factors causing this difference.
<table>
<thead>
<tr>
<th></th>
<th>Mean # of Incarcerations</th>
<th>t-value (degrees of freedom)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female (n = 100)</td>
<td>1.2 (SD = 0.4)</td>
<td>12.8 (248)</td>
<td>.02*</td>
</tr>
<tr>
<td>Male (n = 150)</td>
<td>3.3 (SD = 0.9)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p < .05

**Paired-samples t-test** enables testing the arithmetic mean difference of one variable between paired samples. This test is presented here because it allows for testing differences between two points in time for the same cohort of participants. In other words, the “pair” is the same cohort sampled at two separate times. For example, a provider may want to know if two dates exhibit statistically significant differences in psychiatric hospitalizations – specifically, 12 months prior to FSP participation and 12 months post FSP participation. This question assumes that the provider has data on psychiatric hospitalizations for two points in time for the same cohort of participants (i.e., the analysis represents matched clients). If the finding is statistically significant at the probability level of .05, it suggests a significant change in the number of psychiatric hospitalizations from 12 months pre-enrollment to 12 months post-enrollment. To determine whether the change was positive or negative, simply examine the mean number between pre-enrollment and post-enrollment. If post-enrollment figures indicate fewer psychiatric hospitalizations, the change is positive. The provider might graphically present the findings in this way:

![Graphic of Average # of Psychiatric Hospitalizations](image)

The provider typically would report the same values for a paired-samples t-test. As the table below indicates, the p-value is well below the .05 cutoff; therefore, the provider reports with greater confidence that the difference in the number of psychiatric hospitalizations between these two points in time for the same FSP clients was not due to chance alone. While this analysis does not necessarily validate a conclusion that the FSP program caused the change over time, it might suggest the existence of a relationship between reductions in psychiatric hospitalizations and FSP participation. This claim would be better supported if the provider had a comparison group that showed no significant improvements in psychiatric hospitalizations within the same time frame.
Mean # of Incarcerations | t-value (degrees of freedom) | p-value
--- | --- | ---
Pre-test (n = 100) | 4.2 (SD = 2.7) | -28.3 (99) | .001*
Post-test (n = 100) | 1.7 (SD = 0.6) | | 

* p < .05

Example of How to Use an ANOVA

In simple terms, an analysis of variance (ANOVA) is similar to the t-test, except it permits more than two attributes to be analyzed. For example, a provider wants to know if a statistically significant difference in the number of incarcerations for the same FSP participants occurs across three points in time (at intake, and at 6 months and 12 months after enrollment). Because the provider wants to include more than two time points, a one-way ANOVA test rather than a t-test must be used. The overall ANOVA test might result in statistical significance at the probability level of .05, but specific differences between the time points may not be present. Therefore, additional tests within the ANOVA test are needed to determine which time points differ significantly from one another in the number of incarcerations.

The provider might graphically present the findings by showing the average for each point in time (as the diagram below indicates). The line across the three bars in the graph indicates the benchmark of 2.0 incarcerations on average for a statewide sample of adults with mental illness. At intake, the average for the sample was higher (3.0). At 6 months, the average decreased (to 2.3). Finally, at 12 months, the average for the sample of participants dropped below the statewide average to 1.5 incarcerations.

The following is an example of a table that presents the typical information reported for a one-way ANOVA. The p-value of .01 indicates a statistically significant difference in the average number of incarcerations among the three points in time. Examination of only the mean values of incarcerations for each racial group might prompt a conclusion that the differences are large enough to be statistically significant. The statistical test verified that. Yet visual examination of the mean is no guarantee that the differences will or will not be statistically significant. The test results are based on numerous factors, including sample size. If samples
sizes are too small – for example, 25 clients – significant differences are more difficult to
detect. In contrast, significant differences are more easily detected with larger sample sizes
– for example, 500 clients. (Refer to the “Conducting Quantitative Data Analysis” tool.)

<table>
<thead>
<tr>
<th></th>
<th>Mean # of Incarcerations</th>
<th>Sum of Squares</th>
<th>Degrees of freedom</th>
<th>F</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake (n = 200)</td>
<td>3.0 (SD = 0.7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At 6 months (n = 200)</td>
<td>2.3 (SD = 1.1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At 12 months (n = 200)</td>
<td>1.5 (SD = 1.3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td></td>
<td>3.81</td>
<td>2</td>
<td>8.45</td>
<td>.01*</td>
</tr>
<tr>
<td>Within Groups</td>
<td></td>
<td>26.10</td>
<td>197</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05

**Example of How to Use a Chi-Square Test**

The chi-square test is used when both variables to be studied consist of nominal-level data. For example, a provider may wish to determine if a statistically significant difference in employment outcomes occurs across racial groups. The employment data is nominal level and is collected at the 6-month point of FSP participation. The attributes are “never employed” (within this 6-month period), “part-time employed for at least one month,” and “full-time employed for at least one month.” Three attributes constitute the employment variable, while multiple attributes exist for the variable of race. A chi-square test calculates the proportional differences in these attributes across the racial groups. The provider might graphically present the findings in this way:

![Employment Status at 6 Months Post-Enrollment](image)

The following is an example of a table that presents the typical information reported for a chi-square test. The p-value is .01; therefore, the proportional differences in employment status among the three racial groups are statistically significant. The percentages suggest a pattern in the results. For African American clients, part-time employment is more common than no employment or full-time employment within the first 6 months of FSP participation. For Caucasian clients, full-time employment is slightly less common than no employ-
ment but much more common than part-time employment, whereas for Latino clients, no employment is the most common status. Across the racial groups, Caucasians have full-time employment in greater proportion than the other ethnic groups shown, whereas Latinos account for the greatest proportion of clients who never were employed. A program administrator might generally deduce from these findings that employment outcomes are related to racial affiliation. This analysis, however, does not clearly indicate whether these differential outcomes are related to the FSP program.

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Part-time</th>
<th>Full-time</th>
<th>Chi-square value</th>
<th>Degrees of freedom</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American (n = 70)</td>
<td>35%</td>
<td>50%</td>
<td>15%</td>
<td>137.5</td>
<td>204</td>
<td>.01*</td>
</tr>
<tr>
<td>Caucasian (n = 100)</td>
<td>30%</td>
<td>20%</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latino (n = 30)</td>
<td>65%</td>
<td>25%</td>
<td>10%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05

Example of Applying the Annualization Factor to Data

FSP programs collect 12 months of pre-enrollment historical data for every client enrolled in the program. This information is then compared to their post-enrollment statistics. However, most members have not been in the program for exactly one year. They may have been in the program anywhere from 1 day to several years. Enrollment statistics are further complicated by changes that occur with every new enrollment and withdrawal from a program, resulting in day-to-day variances.

The length of time the FSP program has been in operation may be used to calculate an annualization factor that enables accurate comparison of pre-enrollment and post-enrollment data. For example, if a particular county’s FSP program has been in operation for 15 months, total hospital days post-enrollment would be divided by 15 to equal one month, and then multiplied by 12 to equate to 12 months. This same calculation could be used for all post-enrollment data for that county.

However, a calculation based on the length of time a program has been in operation is significant flawed. That approach tends to result in “over-correction” because it assumes that all clients have been in the program since the day the program began. The program’s post-enrollment reductions in areas such as hospitalization and incarceration consequently appear slightly better than they actually are. Greater accuracy can be achieved by annualizing the post-enrollment data based on the average length of enrollment for all clients in that program. Using that method, the data more accurately compare one year pre-enrollment to one year post-enrollment statistics.

Here is a step-by-step demonstration, using hypothetical information, of how to perform a calculation for annualizing post-enrollment data.
1. Calculate the average tenure of the currently enrolled clients in the program. Consider the following (hypothetical) program in which 10 members are enrolled.

<table>
<thead>
<tr>
<th>Member</th>
<th>Length of Stay in Program (in days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>398</td>
</tr>
<tr>
<td>2</td>
<td>243</td>
</tr>
<tr>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>4</td>
<td>579</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>634</td>
</tr>
<tr>
<td>7</td>
<td>132</td>
</tr>
<tr>
<td>8</td>
<td>234</td>
</tr>
<tr>
<td>9</td>
<td>89</td>
</tr>
<tr>
<td>10</td>
<td>254</td>
</tr>
<tr>
<td>Total</td>
<td>2,590</td>
</tr>
</tbody>
</table>

The 10 currently enrolled members have spent an aggregate total of 2,590 days in the program. Because the program has 10 members, divide 2,590 by 10 to arrive at an average tenure of 259 days per member.

2. Divide one year (365 days) by the average tenure, which yields the annualization factor:

\[
\frac{365 \text{ days in a year}}{259 \text{ average tenure days}} = 1.41 \text{ annualization factor}
\]

3. Finally, apply the annualization factor to the post-enrollment cumulative data by multiplying the non-annualized post-enrollment hospital days by the annualization factor.

Non-annualized Number of Hospital Days Post-Enrollment = 923

\[923 \times 1.41 = 1,301\]

**Annualized Number of Hospital Days Post-Enrollment = 1,301**

Thus, a program that has an average length of enrollment of LESS than a year (as in this example), will have post-enrollment numbers that are GREATER than its raw numbers. A program that has an average length of enrollment of MORE than a year will have post-enrollment numbers that are SMALLER than its raw numbers. And, of course, if the average tenure was EXACTLY 1 year, then the annualized numbers and the raw numbers would be equal.

Note that the **size** (i.e., actual number of members) of the program has little influence on the annualization factor, while the **average tenure** of all the members has a major impact. Because recovery is a long-term process and FSPs need some time to demonstrate their effectiveness, **the methodology of applying the annualization factor to post-enrollment data is advisable only when the average tenure of the FSP members is at least 6 months (182.5 days)**. Annualizing data when the FSP program’s members have an average tenure of less than 6 months is unlikely to accurately reflect the FSPs impact on its members’ quality of life (as defined by reductions in hospitalization or incarceration or increases in employment or education).
Drawing Evaluative Conclusions

**Purpose**

To justify conclusions against agreed-upon standards set by the stakeholders.

**Definition**

Common steps to *drawing evaluative conclusions* include: (1) examining the findings against agreed-upon standards; (2) interpreting the findings or giving meaning to the findings; (3) judging a program or performance, or making claims of merit, worth, or significance; and (4) recommending actions based upon evaluation findings.
Implementation Strategies

- Use culturally appropriate methods of analysis and synthesis to summarize findings. To do so, involve stakeholders in deducing meaning from data. For example, do “member checking” by sharing evaluation findings with stakeholders to verify the findings and any interpretations of the findings.

- Interpret the significance of results for deciding what the findings mean. Statistical significance and practical significance differ from one another. The latter type of significance refers to the meaning of findings in the real world as it relates to people, organizations, and society. Interpreting the practical or clinical significance of a finding typically requires considering the context of the finding. For example, a single-room occupancy (SRO) unit is one indicator of a stable living situation, representing improvement for a client. Yet the contextual information about the current living situation gives greater meaning to the finding. That is, if the client had been homeless (rather than living in an apartment) before moving into an SRO, the finding suggests a clinically significant improvement that sheds light on the degree of change for this particular client.

- Make judgments according to clearly stated values that classify a result. For example, was the finding positive or negative, high or low, an increase or a reduction?

- Consider alternative ways to compare results. For example, compare with program objectives, a comparison group, national norms, past performance, or needs. Such considerations facilitate quality improvement measures by defining the meaning of the finding. Is a 10 percent increase in employment for FSP clients a positive or negative finding? To give meaning to this figure, compare it against that of similar counties or programs, either locally or nationally.

- Generate alternative explanations for findings, and indicate why these explanations should be discounted. This is an important strategy for responding to potential critics of the evaluation findings.

- Recommend actions or decisions that are consistent with the conclusions. When recommendations are based on the evidence presented, they are
Implementation Strategies (cont’d)

more likely to resonate with stakeholders. In other words, avoid making sweeping recommendations without backing them up with justified conclusions.

- Limit conclusions to situations, time periods, persons, contexts, and purposes for which the findings are applicable.

Selected Sources of Standards for Judging Program Performance

- Needs of participants.
- Community values, expectations, and norms.
- Degree of participation.
- Program objectives.
- Program protocols and procedures.
- Expected performance, forecasts, and estimates.
- Feasibility.
- Sustainability.
- Absence of harm.
- Targets or fixed criteria of performance.
- Change in performance over time.
- Performance by previous or similar programs.
- Performance by a control or comparison group.
- Resource efficiency.
- Professional standards.
- Mandates, policies, statutes, regulations, and laws.
- Judgments by reference groups (e.g., participants, staff, experts, and funding officials).
- Institutional goals.
- Political ideology.
- Social equity.
- Political will.
- Human rights.
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 147–150. This guide enables you to focus on the pertinent resources linked directly to each tool.

<table>
<thead>
<tr>
<th>Name of Tool</th>
<th>Resource Number(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparing for Data Analysis</td>
<td>6, 7, 8, 9, 11, 12, 13, 14, 18, 19</td>
</tr>
<tr>
<td>Conducting Quantitative Data Analysis</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 28</td>
</tr>
<tr>
<td>Applying Statistical Techniques to FSP Evaluations</td>
<td>15, 16, 17, 25, 26, 27</td>
</tr>
<tr>
<td>Drawing Evaluative Conclusions</td>
<td>20, 21, 22, 23, 24</td>
</tr>
</tbody>
</table>
✔ Books


✔ Computer Software

(freeware annotated with an asterisk)


✔ County Report Examples – Using Statistical Tests and/or Annualized Estimates


✔ Reports


✔ Standards


✔ Training and Workshops for Evaluation


✔ Website

Communicate Progress and Findings

Disseminating information about the progress and findings of the evaluation is the final step in the process; however, communication is important from the beginning to the end of the evaluation process. Effective communication ensures that evaluators and the program staff benefit from participants’ perspectives on program and evaluation goals and priorities, and maximizes the cultural relevance, value, and use of the evaluation. As with data analysis, communication about the evaluation should not be an afterthought. Communicating throughout the evaluation is an important means of encouraging use of findings. Several aspects of communications warrant consideration, including the purpose of communication, intended audiences, format, frequency, and timing. These aspects are covered in the topics that follow.
Purpose

To communicate evaluation findings for utilization and continuous quality improvement.

Definition

As part of the evaluation process, communicating evaluation findings is key. The purposes of communication include:

- Promoting collaborative decision making about evaluation design and activities.
- Informing stakeholders and program participants about specific upcoming evaluation activities.
- Conveying information about the evaluation progress to people who are directly and indirectly involved.
- Presenting and sometimes collaboratively interpreting initial, interim, and final findings.
Implementation Strategies

- Identify the various levels of data utilization across the organization and stakeholder groups (e.g., line staff, mid-level managers and supervisors, administrators, and policy makers). Then tailor the communication, based on the utility of evaluation findings, to those organizational levels and stakeholder groups. Doing so not only promotes evaluation utilization, but also facilitates evaluation implementation. When evaluation findings are useful to stakeholders who participate in data collection, this perceived or real utility likely improves data accuracy and completion rates for data collection and entry. The example below illustrates applications across several organizational levels.

<table>
<thead>
<tr>
<th>Report Contents</th>
<th>Example of Indicators</th>
<th>Stakeholder/Policy Applications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client profile and service</strong></td>
<td>• Counts and central tendencies</td>
<td>• Service population descriptions</td>
</tr>
<tr>
<td><strong>utilization</strong></td>
<td>• Demographics by utilization of services and length of services</td>
<td>• Access, engagement, and retention issues (i.e., disparities analysis)</td>
</tr>
<tr>
<td></td>
<td>• Retention rates – e.g., proportions of premature withdrawal or short length of service</td>
<td>• Continuous quality improvement</td>
</tr>
<tr>
<td><strong>Fidelity</strong></td>
<td>• Service process, FSP program intent and/or evidenced-based practice program fidelity measurement</td>
<td>• Continuous quality improvement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Contract performance and funding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Policy interpretation of MHSA outcomes</td>
</tr>
</tbody>
</table>
Example: Categories of Reports and Potential Relevance to Stakeholder Types

<table>
<thead>
<tr>
<th>Satisfaction</th>
<th>Outcomes and differential outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Percentage of endorsements by service process and/or provider</td>
<td>• Pre-enrollment and post-enrollment average scores on standardized measures</td>
</tr>
<tr>
<td>• Continuous quality improvement</td>
<td>• Proportions above and below clinically meaningful cutoffs</td>
</tr>
<tr>
<td>• Client voice and feedback</td>
<td>• Outcomes by demographics</td>
</tr>
<tr>
<td></td>
<td>• Other correlates and predictors of results</td>
</tr>
<tr>
<td></td>
<td>• Staff tracking of client progress</td>
</tr>
<tr>
<td></td>
<td>• Continuous quality improvement</td>
</tr>
<tr>
<td></td>
<td>• Contract performance and funding</td>
</tr>
<tr>
<td></td>
<td>• Policy interpretation of MHSA outcomes</td>
</tr>
</tbody>
</table>

- **Line staff** – Because line staff members usually collect data and implement practices, evaluation findings must be communicated to them in a way that is useful and pertinent to their work. Explanation of the relevance will encourage their participation in the evaluation process and increase the likelihood that they will apply the evaluation findings to their own work with clients. At the same time, the communication of evaluation findings (i.e., how and in what format communication is achieved) must be sensitive to their time constraints. Therefore, communication should be targeted and aligned with their everyday practice as line workers.

When preparing to communicate evaluation findings to line staff members, start with data that are meaningful to them. Information related to the individual client level will be of greatest interest to staff members. A decision support tool usually referred to as a patient or client registry offers a useful way to communicate findings at this level, by enabling line staff and their immediate supervisors to evaluate their
effectiveness in serving the clients with whom they work. The specific content of the data will vary according to the population being served and the intended outcomes of the program. Regardless of content, a good registry is able to show change (or the lack of it) in outcomes over time, and guides line staff members and their supervisors in considering whether and how to change their practices to achieve better outcomes.

Managers, supervisors, and the line staff can work together to develop a registry that is appropriate for their population and reflects the outcomes that they are trying to achieve.

- **Administrators** – Client-level data may be of value to administrators. They may be further interested in aggregate reports based on client-level data that show, for example, the proportion of ethnic minorities served, average score on a depression scale at pre-enrollment and post-enrollment, overall client satisfaction, units of service, and average length of stay in the program.

Managers and administrators can benefit from aggregate-level data in a quality improvement context by using it to guide decisions about which practices and outcomes they should attempt to change to enhance program performance. For example, if the data indicate that a program has ethnic disparities in the population served compared to the general population of the program’s service area, the program could implement a small-scale test/PDSA (plan-do-study-act) cycle to try to reduce the disparities. The data also can suggest reasonable performance improvement expectations as well as the time frames during which the improvements are expected to occur. Consult the “Resources” segment in this domain for reference to an improvement guide for organizational performance.
Administrators also may be interested in reports on fidelity to the practice model. Tracking fidelity involves basic information about program performance – for instance, information that reflects the contractual agreement between the county and provider. This information is useful in characterizing the functions and achievements of the program, as a means of furnishing a contextual framework when outcomes are presented. In their role as administrators, they need to share the significance of these results without getting lost in the numbers. Therefore, their understanding of client level data that can get rolled up into aggregate reports is an important starting point for better communicating the meaning of aggregate results to various stakeholders.

Leaders, policy makers, and community stakeholders – Aggregate reports can help leaders, policy makers, and community stakeholders determine benchmarks for performance across similar programs and systems. In this way, top-performing programs and the practices that lead to their outcomes can be identified and used in quality improvement functions. In addition, these stakeholders may be interested in cost effectiveness and study reports that correlate the application of evaluation findings to a larger population of clients.

Remember quality improvement is enhanced in proportion to how often evaluation findings are communicated. The purpose and nature of the data will to some extent determine the frequency of reports (e.g., “annual” report); for changes in performance outcomes to occur, however, direct service staff members must receive regular reports that allow them to determine if the practice changes they are implementing are having the intended affect. Ideally, reports of program performance should be issued monthly, and the minimal standard for frequency of performance outcomes reports should be quarterly.
Implementation Strategies (cont’d)

- Be accurate in communicating evaluation findings. As Domain 5 (Analyze and Draw Evaluative Conclusions in Data Analysis) indicates, conclusions drawn from evaluation findings must be consistent with the limits of the research design. Unless the evaluation uses rigorous evaluation designs such as experimental designs, conclusions about evaluation findings should avoid suggesting causality (i.e., the FSP program caused a certain outcome). Even the use of inferential statistics (e.g., t-test and analysis of variance) for descriptive purposes must be done with caution. Small counties with small sample sizes, and counties with data sets that are not normally distributed, could use nonparametric tests (e.g., a chi-square test) to analyze their data. (See Domain 5 for further information.)

- Read the following article:

  APPENDIX A: How Does One Measure Recovery?

- Refer to the following appendices for example reports:

  APPENDIX B: DCR Residential Follow-Up
  APPENDIX C: FSP Report – Ventura County
  APPENDIX D: MHSA Report – Adult FSP, Los Angeles County
  APPENDIX E: MHSA Report – TAY Living Situation, Santa Clara County
  APPENDIX F: MORS – Two Examples of Aggregated Reports from MORS Data.
  APPENDIX G: Recovery Oriented Registry Example – Mental Health America of Los Angeles
  APPENDIX H: Utilizing Data Reporting and Findings – Orange County
Knowing the Audience for Project Communication

Purpose
To consider the culture and characteristics of the audience in communication.

Definition
The culture and characteristics of the audience are important to consider. Be sure to know the audience when designing and delivering project communication.
Implementation Strategies

Consider the characteristics and cultural values of all evaluation stakeholders when designing and delivering project communication. Tailor communications to the cultural norms and needs of the particular audience for which they are intended. Contemplate these factors:

- **Accessibility** – Be sure that the intended audience has access to the communication. That is, if posting communications on a website, be sure the audience has regular access to a computer with Internet access. Ensure access by creating culturally appropriate forums for communication. Use culturally competent strategies discussed throughout this Tool Kit to improve accessibility. For example, if the audience is composed primarily of Latino clients and their families, use community settings (e.g., local schools) to have a family event.

- **Reading ability and language** – Gear written communications to the average reading level for the stakeholder audience that one is targeting. Translate materials into languages spoken and read by the target audience.

- **Familiarity with the program and/or the evaluation** – Be sure to explain the program and its evaluation in communications with audiences that may not be familiar with the work.

- **Role in decision making** – Determine whether this audience will be using the information in the communication for decision making, and tailor the communication to these needs.

- **Familiarity with research and evaluation methods** – Consider whether the audience will want a description of the methods, and if not include it as an appendix. Avoid technical jargon when describing research and evaluation methods.
Experience using evaluation findings – Consider the extent to which the intended audience may be familiar or unfamiliar with thinking about and using evaluation findings to make decisions about a program.
Communicating and Presenting Information Using Formal and Informal Formats

Purpose
To determine the format of communication based on the audience and purpose of communication activities.

Definition
*Communicating and presenting information using formal and informal formats* means understanding the makeup of the audience and the purpose of communication activities that define the content of the evaluation that will be communicated. At the same time, the audience and purpose should influence the format of communication – which can take either of two forms: formal and informal formats.
Implementation Strategies

- Use informal communication formats for primary users of evaluation findings, such as line staff members, personnel within provider agencies, and administrators. Informal approaches include:
  - Memos
  - Postcards
  - E-mail
  - Personal discussions
  - Working sessions

- Use formal communication formats for secondary users of evaluation findings, such as policy makers, clients, and community stakeholders. Formal approaches include:
  - Verbal presentations
  - Written reports
  - Executive summaries
  - Websites
  - Social media (Facebook, YouTube)
  - Poster sessions
  - Newsletters

- Prepare for varying levels of interactivity with the audience, depending upon the format of communication. The formats can be classified as “most interactive” (e.g., working sessions and impromptu or planned meetings with individuals); “moderately interactive” (e.g., verbal presentations, videotape or computer-generated presentations, posters, and Internet
Implementation Strategies (cont’d)

communication); and “least interactive” (e.g., memos and postcards, comprehensive written reports, executive summaries, newsletters, bulletins, brochures, and new media communications).

- Present information in a way that facilitates communication among counties, providers, and other stakeholders. Numerous software applications are available to convert spreadsheet and database data into “dashboards.” These applications are relatively inexpensive, and some can even be obtained as freeware on the Internet, enabling counties and programs to explore and present their data in more transparent and stakeholder-accessible ways. Programs and counties may consider an application called Xcelsius that Mental Health America of Los Angeles created; program administrators can use it to compare their own results and outcomes with those of the rest of the their county, or administrators of county agencies can compare their outcomes with those of the state.

- Share evaluation findings with clients. Use a combination of informal and formal formats of communication. For example, if clients are involved in continuous quality improvement (CQI) forums, disseminate information through these forums or work sessions. Use client kiosks located in agencies to distribute newsletters or briefs. Circulate evaluation findings among youth and TAY through social media outlets on the Internet such as YouTube and Facebook using photos and videos. Disseminate evaluation information that is of interest to clients. Ask clients what information they would like to see (e.g., whether the client will become better by participating in the service and whether others who participated were satisfied with the services).
Dashboard Application: Xcelsius

Pictured below is an example of the AB 2034 spreadsheet data from February 2005 and the Xcelsius-based application that allowed users to interact with the data and compare changes in their own program or county with other programs or the state. This example shows a comparison of the reduction in hospital days between Los Angeles County (-66.62%) and the rest of the AB 2034 counties across California (-64.37%), suggesting that Los Angeles County was very close to the state average in its ability to reduce the number of hospital days experienced by its AB 2034 participants. The application makes it much easier to compare results than simply reviewing tables of numbers.

![Annualized Psychiatric Hospitalizations Table](image-url)
Client Dashboard and Assessment Report for Line Staff

Line staff members who are given access to clinical indicators become less reluctant to collect underlying data because they see real-time benefit from their work. Staff members who are shown the same clinical indicators as administrators and policy makers are empowered to work with clients in a way that directly advances system-wide goals.

Client Dashboard

The client dashboard shows “at-a-glance” information about how individual clients are currently functioning, as well as how their functioning has changed over time (if multiple assessments are conducted).

Initial CAFAS (Child and Adolescent Functional Assessment System) Dashboard

<table>
<thead>
<tr>
<th>Total Score</th>
<th>High Risk Behavior</th>
<th>Severe Impairments</th>
<th>Pervasive Impairment</th>
<th>CAFAS Tier</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td>Substance Use</td>
</tr>
</tbody>
</table>
Implementation Strategies (cont’d)

Dashboard Shows Outcomes – Comparison of Initial and Most Recent (Exit) CAFAS

<table>
<thead>
<tr>
<th>Total Score</th>
<th>High Risk Behavior</th>
<th>Severe Impairments</th>
<th>Pervasive Impairment</th>
<th>CAFAS Tier</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td><img src="image" alt="High Risk Behavior" /></td>
<td><img src="image" alt="Severe Impairments" /></td>
<td><img src="image" alt="Pervasive Impairment" /></td>
<td>Mild Problems Only</td>
</tr>
</tbody>
</table>
Implementation Strategies (cont’d)

CAFAS Assessment Report

The CAFAS Assessment Report is a PDF file that has many of the same details as the Client Dashboard. The benefit of a PDF version of a formal report is the ease with which case information can be shared with other members of the treatment team who may not have access to the FAS Outcomes system.

Supervisor Dashboard for Supervisors and Managers

Administrators value easy access to a snapshot of outcomes, at any moment in time across programs, or even throughout the entire organization. That serves the organization’s continuous quality improvement objectives. A PDF file of an Aggregate Outcomes Report can be generated to show a profile of clients served over a selected time period, along with details of the clients’ progress to-
ward recovery. Changes in scores and cases that have shown improvement, as well as those that have not shown improvement, are highlighted in the report. Note that the same clinical indicators shown on the Supervisor Dashboard, the Client Dashboard, and the CAFAS Assessment Report are featured on the Aggregate Report. The Supervisor Dashboard is a dynamic tool that gives supervisors and managers the ability to quickly identify cases in which their expertise can contribute to a client’s recovery. One valuable aspect of the Supervisor Dashboard is its ability to alert supervisors about important areas of concern. With that information, the supervisor can quickly “drill down” from one level of detail to the next until reaching and viewing exactly the same data in the same context in which the line staff views it. The same clinical indicators shown on the Client Dashboard and CAFAS Assessment Report are highlighted on the Supervisor Dashboard.

**Aggregate Report for Administrators**

Administrators will benefit from easy access to a “snapshot” that displays outcomes at any moment in time, across programs, or even the entire organization. Such a broad perspective is fundamentally important for the organization’s process of continuous quality improvement. An Aggregate Outcomes Report generated in PDF format can show a profile of clients served over a selected time period, along with details of the progress toward recovery for those clients. Changes in scores and cases that have shown improvement, as well as those that have not progressed, are highlighted in the report. Note that the same clinical indicators shown on the Supervisor Dashboard, the Client Dashboard, and the CAFAS Assessment Report are featured on the Aggregate Report.
Benchmark data for Leaders and Policy Makers

Leaders and policy makers may encounter difficulty in attempting to collect, compare, and present information across disparate organizations. This information is crucial for development of meaningful policies and system-wide goals. The CAFAS enables collection of data across organizations by means of a robust data export module through which all organizations can extract data at any time into SPSS, CSV, or XML formats. The clinical information collated in the previous views is pre-calculated in the export so that leaders and policy makers are working with the same clinical details as everyone who works directly with the client. Once the data are extracted (and similar programs have been identified to ensure an “apples-to-apples” comparison), comparison of results can be performed with confidence due to the proven reliability of the CAFAS. After the data are consolidated, presenting the information is as easy as creating reports and graphs with a favorite reporting tool. Administrative and clinical managers are able to access all data and reports without support or IT staff.
Purpose

To develop a plan that details the purpose, formats, time lines, and other critical information for dissemination.

Definition

Dissemination is the process of communicating either the procedures or the lessons learned from an evaluation to relevant audiences in a timely, unbiased, and consistent fashion. Agencies’ process of developing a dissemination plan should achieve full disclosure and impartial reporting. The reporting strategy for this and other elements of the evaluation should be discussed in advance with intended users and other stakeholders. Such consultation helps ensure that the information needs of relevant audiences will be met.
**Implementation Strategies**

- Document the evaluation communication plan, detailing the purpose, formats, time lines, and other critical information.

- Develop the dissemination plan collaboratively with stakeholders. Prepare to revisit the plan multiple times throughout the evaluation process. The dissemination plan will evolve, along with any changes in evaluation users, stakeholders, and political climate.

- Include dissemination activities as part of continuous quality improvement (CQI) functions. A dissemination plan is not stagnant, and dissemination activities do not necessarily end when the evaluation concludes. Integrate dissemination activities into CQI activities so that a circular feedback loop is in place to communicate evaluation findings and to utilize evaluation findings to achieve improvements in practice.

<table>
<thead>
<tr>
<th>Sample Dissemination Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Audience: Parents and Youth at the Pilot Sites</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Possible Formats</th>
<th>Timing/Dates</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include in decision making about evaluation design and activities</td>
<td>Personal discussions and meetings</td>
<td>Early April</td>
<td>Pilot parent survey</td>
</tr>
<tr>
<td>Inform about specific upcoming evaluation activities</td>
<td>Article included in site newsletter</td>
<td>Early September</td>
<td></td>
</tr>
</tbody>
</table>
| Keep informed about progress of the evaluation | • Agency Facebook page  
• E-mail  
• Evaluation brief (1-page) in client kiosks | Ongoing | |
Ensuring Effectiveness of Evaluation Reports

Purpose

To create evaluation reports that are useful and timely.

Definition

Although a formal evaluation report is not a necessary product of every evaluation, it is a commonly used means for communicating what, why, how, and when a program was evaluated, along with the conclusions of the evaluation. Ensuring effectiveness of evaluation reports can occur through numerous strategies, including attentiveness to their usefulness and timeliness.
Implementation Strategies

Use this checklist of measures to ensure the effectiveness of evaluation reports by

- Distributing interim and final reports to intended readers in time for use. Interim reports are helpful in formal and regular communication about the evaluation findings.
- Tailoring the report content, format, and style for the audience(s) by involving audience members.
- Including a summary of the evaluation findings.
- Characterizing the stakeholders and explaining how they were engaged.
- Describing essential features of the program (e.g., inclusion of logic models).
- Explaining the focus of the evaluation and its limitations.
- Including an adequate summary of the evaluation plan and procedures.
- Including all necessary technical information (e.g., in appendices).
- Specifying the standards and criteria for evaluative judgments.
- Explaining the evaluative judgments and how they are supported by the evidence.
- Listing both strengths and weaknesses of the evaluation.
- Discussing recommendations for action with their advantages, disadvantages, and resource implications.
- Ensuring human subjects protections to mitigate possible harm and ensure confidentiality for program clients and other stakeholders.
Implementation Strategies (cont’d)

- Anticipating how people or organizations might be affected by the findings.
- Presenting minority opinions where necessary.
- Verifying that the report is accurate and unbiased.
- Organizing the report logically, and including appropriate details.
- Avoiding technical jargon.
- Using examples, illustrations, graphics, and anecdotal evidence.
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 176–179. This guide enables you to focus on the pertinent resources linked directly to each tool.

<table>
<thead>
<tr>
<th>Name of Tool</th>
<th>Resource Number(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicating Evaluation Findings</td>
<td>6,8,9,10</td>
</tr>
<tr>
<td>Knowing The Audience for Project Communication</td>
<td>17</td>
</tr>
<tr>
<td>Communicating and Presenting Information Using Formal and Informal Formats</td>
<td>2,3,5,7</td>
</tr>
<tr>
<td>Developing a Dissemination Plan</td>
<td>16</td>
</tr>
<tr>
<td>Ensuring Effectiveness of Evaluation Reports</td>
<td>1,4,11,12,13,14,15</td>
</tr>
</tbody>
</table>
✔ Articles


✔ Books


Dashboard Application


Fidelity Assessment


Functional Assessment Scale


Guidebook


Information System


Report Generator


13. Riverside County Department of Mental Health Research and Evaluation. (2011). (2011). FSP outcomes report. Riverside County Department of Mental Health Research and Evaluation. Riversite, CA. (This report is not available online. For more information, contact Suzanna Juarez-Williamson, Supervisor, Research and Evaluation, Riverside County Department of Mental Health at SJWilliamson@rcmhd.org or 951-955-7142.)


✔ Tool


✔ Tool Kit

bivariate analysis. Examination of the distribution of cases on two variables at a time.

data collection. Any of various ways of collecting data, including (but not limited to), surveys, interviews, focus groups, observations, document reviews, and tests (assessments).

descriptive statistics. A method involving reduction of data for presenting quantitative descriptions in a manageable form (e.g., percentages and arithmetic means).

design. Scientific research options that fall under three categories: experimental design, quasi-experimental design, and non-experimental (or observational) design.

dissemination. The process of communicating either the procedures or the lessons learned from an evaluation to relevant audiences in a timely, unbiased, and consistent fashion.

evidence-based practice. Use of research and scientific studies as a base for determining the best practices in the field.

expected effects. The results that the developers of a program intend to achieve. Because the effects of most FSP programs are expected to unfold over time, anticipated effects are organized and presented as short-term, intermediate, or long-term outcomes.

indicators. Means of translating general concepts about a program, its context, and its expected effects into specific measures that can be interpreted.

inferential statistics. Techniques to make assertions about the larger population of a sample or to explain the causal processes of the relationships observed in the data.

intermediate outcomes. Findings determined in part by short-term outcomes. Typically, intermediate outcomes indicate changes in behavior, decisions, and policies.

levels of measurement. Scales of measurement expressed as nominal (or categorical), ordinal, interval, and ratio calculations.

logic model. A common tool used to describe programs. It provides a road map of a program typically in the form of a flow chart, map, or table to portray the logical sequence of steps leading to program results. The logic model documents expected effects or outcomes, and it clarifies knowledge about what works and why.

long-term outcomes. Results to which short-term and intermediate outcomes contribute. Typically, long-term outcomes indicate a change in individual or group behavior or community conditions. Long-term outcomes reflect a larger social consequence.
mixed methods. Approaches using both quantitative and qualitative methods to evaluate a program (see definition of quantitative and qualitative research).

outcome questions. Inquiries about program effects, results, or impact on program participants.

outcomes. The results of outputs or program processes, such as the number or percentage of mental health screenings.

participatory evaluation. A partnership approach to evaluation in which stakeholders actively engage in developing the evaluation and all phases of its implementation.

performance benchmarking. Setting levels or standards against which quality is measured, as a way of identifying and learning good practice.

primary users of evaluation. A subset of all stakeholders identified (i.e., individuals who are in the position to do or decide something about the program).

process questions. Inquiries about the status of program resources, activities, and outputs. They help to describe what the program is doing, by whom, and for whom.

program activities. Functions of a program designed to effect change.

qualitative research. A method of inquiry for understanding a social or human phenomenon defined by words that describe detailed information about the phenomenon.

quality improvement. Actions taken throughout an organization to increase the effectiveness of activities and processes to increase or enhance benefits to the both the organization and its stakeholders.

quantitative research. Numerical representation and manipulation of observations for the purpose of describing and explaining a phenomenon.

reliability. Refers to the consistency of measurement. For example, a reliable scale would consistently report the same weight if you measured your weight multiple times in a row.

short-term outcomes. The direct result of program activities. Typically, short-term outcomes indicate a change in knowledge, attitudes, motivations, and skills.

stakeholder. Any person, group, or organization with a vested interest in the knowledge gained from the evaluation and the actions taken as a result of the knowledge.

stakeholder engagement. Action of bringing stakeholders into the evaluation decision-making process. Other terms such as “involvement,” “participation,” and “consultation” are used interchangeably to describe this action.

unit of analysis. The unit is the major entity that is being studied (e.g., individuals, groups, artifacts).

univariate analysis. The examination of the distribution of cases one variable at a time.

validity. Refers to the extent to which something measures what it claims to measure. A valid scale would report your correct or true weight.
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How Does One Measure Recovery?

The concept of recovery has become the dominant paradigm in the adult community mental health field. Administrators, academics, and clinicians, as well as people in recovery from mental illness (clients), refer continually to the need for “recovery-based” services and “recovery-oriented” systems. The meaning of the term “recovery,” however, is subject to a wide range of interpretations; it is difficult to define, yet most people know it when they see it.

Recovery is not a unitary concept, and the lack of unity derives primarily from two sources: 1) the perspective of the individual or group defining recovery, and 2) variability in viewing recovery primarily as a set of general and specific practices (a “journey”) or rather as a set of outcomes (a “destination”).

Recovery and the importance of perspective

People who directly experience recovery from a mental illness (or from substance abuse or trauma of any kind) have a unique perspective that distinguishes them from all others who have no such first-hand experience. The subjective, lived experience of people in recovery informs their meaning of recovery in ways that are not directly accessible to other stakeholders in the mental health system (e.g., clinicians, family members, administrators, or the general public). This experience is often fraught with stories of disempowerment and mistreatment at the hands of mental health professionals. But it also consists of stories of hope and empowerment – what the mental health system provided (and often more importantly, how it was provided) that people in recovery found helpful in their recovery. People in recovery have an understanding of the meaning of recovery that is strongly determined both by what it “feels like” to be in a state of recovery as well as by the general and specific practices of mental health providers that assisted in their recovery.

This is not meant to imply that the perspectives of mental health administrators, clinicians, family members and researchers are identical. Obviously, these different stakeholder groups have their own agendas that are sometimes at odds with each other. For example, family members may be primarily concerned with keeping their loved one safe from harm, while a clinician may be primarily concerned with assisting a person in recovery to live more independently. However, for the purposes of defining the meaning of “recovery-oriented,” these other stakeholders have much more in common with each other than they do with the perspectives of people in recovery because they all have an outsider’s perspective on the individual’s recovery.

Of course, the perspectives of other key stakeholders are no less important to consider than the subjective experience of the person in recovery. In a recovery-oriented system of care, perspectives of multiple stakeholders must be attended to simultaneously. For example, legislators and
administrators are likely to care most about creating programs that reduce adverse effects such as hospitalization and incarceration, because these events are the most visible to their constituents and have direct implications for their tax burden. On the other hand, improved self-esteem, a greater sense of hopefulness, greater empowerment, or subjective experiences of people in recovery are unlikely to be as salient to the general public or their elected representatives.

Outcome measures in general and recovery outcome measures in particular rarely reconcile with the perspectives of all relevant stakeholder groups. Therefore, for the purpose of defining the “expected effects” (in this case, “recovery”) of FSP programs, clarity about whose perspective the selected outcomes are expected to represent and serve is essential. Recognition of the unlikelihood that any single measure of recovery will be adequate to satisfy all stakeholders also is important. The perennial limitations of resources require prioritization of stakeholder perspectives when selecting a recovery measure intended to define the expected effects of an FSP program.

The journey vs. the destination (recovery-oriented care vs. recovery-oriented outcomes)

The wide variation in the essential qualities of recovery also are due to the differences that arise in perceiving recovery primarily as a process (“the journey”) in contrast to viewing it primarily as an outcome (“the destination”). The idea that recovery has no final endpoint is illustrated by the often-quoted statement of many people who have experienced recovery from substance abuse: “I am never recovered, but I am always recovering.” This statement reflects an emphasis on the ongoing attention that many people in recovery believe they must pay to their own process of recovery.

Indeed, the constant reminders to “work the program” (from self and others) tend to separate the day-to-day process from a connection to any but the most short-term of outcomes.

This focus on the individual process of recovery has an analog at the mental health program and system level. It can be framed as: “What are the general and specific practices (‘recovery-oriented care’) by our providers that are likely to lead to the recovery of the people we serve?” The term “specific practices” is intended to refer primarily to the practices and techniques that have been demonstrated through research to exert a strong influence on the likelihood of recovery of a person (evidence-based practices). The term “general practices” refers primarily to perhaps less well-defined but no less important aspects of the relationship between provider and consumer – factors that are often put under the constructs of the “therapeutic relationship” and/or the provider’s “organizational culture.”

Of course, complete separation of practices from outcomes is impossible. If you are on the mainland and you want to travel to Hawaii, you can’t reach it by car – you have to take a plane or boat (or swim, but this is likely to be ineffective). Conversely, if your only means of transportation is a bicycle, your ability to travel will be limited. These two examples have analogs in our mental health systems: If a program doesn’t offer the recovery-oriented care and practices that have been shown to be effective (e.g., supported employment), people in recovery are unlikely to experience an improved outcome (e.g., greater employment). On the other hand, programs that offer only one type of practice, even if it is evidence-based, are unlikely to achieve improved outcomes if people in recovery (or other stakeholders) desire outcomes that the specific or general practices of the program are unlikely to achieve.

Traditionally, mental health programs and systems tend to focus more on processes and practices than on outcomes. However, movement toward holding mental health providers accountable for their performance in producing beneficial outcomes appears to be gaining momentum. This suggests that defining the meaning of “recovery-oriented” outcomes will become increasingly important. McGlynn (1996) described several major domains of outcome measurement for mental health programs. These include clinical status (how a disorder is defined, particularly in
terms of the presence and severity of symptoms); functional status (the ability of an individual to perform age-appropriate activities); quality of life (the subjective perception of satisfaction with one’s life situation); and adverse events (negative outcomes such as hospitalization, mortality, and incarceration that result from system problems that could be avoided with appropriate care).

No one would suggest that these domains are unimportant. In fact, for some stakeholders (legislators and the larger public), the reduction of adverse impacts may be the primary outcome with which they are concerned. In all likelihood, people in recovery themselves are also interested in reducing hospitalization, mortality, and incarceration, if only from their personal investment in these events. But do these domains adequately capture the essence of what recovery means? Decreased symptoms and increased functioning, the traditional outcome domains of interest to the mental health system, are inadequate to describe what is meant by “recovery-oriented” outcomes because they are driven solely by the individual’s illness. Because recovery implies the re-claiming of all aspects of one’s life, “recovery-oriented” outcomes comprise the same domains that generally would be considered essential to a “meaningful” and “satisfying” life, regardless of the presence or absence of a mental illness.

The Recovery Question Matrix

Building on the foregoing discussion, the two dimensions of (1) person in recovery vs. other stakeholder perspective and (2) practices vs. outcomes focus can be arranged in a 2 X 2 matrix, as shown in Figure 1. This diagram illustrates the complementarity of ways of understanding the concept of recovery that are ordinarily considered very disparate.

<table>
<thead>
<tr>
<th>Practices</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perspectives of people in recovery</td>
<td>I. What are the practices, supports, and organizational cultures that people in recovery have found to be helpful in their recovery?</td>
</tr>
<tr>
<td>Perspectives of other stakeholders (providers, administrators, family members, researchers, funding authorities, the general public)</td>
<td>III. What are the practices, supports and organizational cultures that have been shown empirically to improve the outcomes of people in recovery?</td>
</tr>
</tbody>
</table>

Figure 1. The Recovery Question Matrix

Depending on one’s perspective and focus, the essential “recovery question” in which one is likely to be interested varies greatly. For example, people in recovery with a practice focus (quadrant I) tend to be interested in the specific and general provider practices that lead to a subjective, internal experience of recovery. Family members who want their loved one to receive the best possible care are likely to focus on quadrant III. Funding authorities and the general public are likely to be less
interested in the “practices” half of the matrix. Their interests will reside primarily in improvements in objective quality of life indicators (quadrant IV) because of the public policy implications those indicators have.

The arrows depict certain assumptions regarding the manner in which practices and outcomes interact. The practices that people in recovery have found helpful in their recovery are assumed to most strongly affect the individual’s subjective experience of a meaningful and satisfying life. Similarly, specific evidence-based practices are expected to have the strongest effect on changes to the individual’s objective quality of life. As a result of a bidirectional relationship that exists between quadrants II and IV, improving outcomes in either of these areas is likely to lead to improvement in the other. Indeed, most providers’ intuitive model of the change process is based on the assumption that internal, subjective change precedes external improvement in objective quality of life. This is certainly true at least some of the time. However, sometimes external improvements in the quality of life can very likely produce significant improvement in one’s internal subjective experience. For example, getting off the street may significantly increase hopefulness. Having a steady job and paycheck can improve self esteem.

Specific outcome measures, many of which are referenced throughout this Tool Kit, are designed to answer the four recovery matrix questions. In selecting a measure that is intended to evaluate an FSP’s ability to improve the rate of recovery in its adult clients, be certain to clearly define whose perspective is being served by the evaluation and whether the evaluation focuses on the care that produces the outcomes or instead on the outcomes themselves. Finally, remember that recovery involves more than reduction of symptoms or improvement of functioning. The Practice Guidelines for Recovery-Oriented Care for Mental Health and Substance Use Conditions (2008) stated: “Mental Illness is only one aspect of a person who otherwise has assets, strengths, interests, aspirations, and the desire to continue to be in control of his or her own life” (p. 20).

References


DCR Residential Follow-Up

Example of DCR Residential Follow-Up Report

This residential report summarizes, by age group, all clients who have completed at least one full year in an FSP (e.g., for adults, N = 312). The key components of the report are summarized here:

**Baseline** – The total number of days at baseline are aggregated from the partnership assessment form (PAF) by residential category (see the last page of the report for a crosswalk with DCR language). The percentage under baseline shows how the days themselves are distributed across all residential categories.

**Partnership** – Under “partnership,” the number of days is accumulated from the figures that KETs submitted for just the first year in treatment. Because baseline is defined as one year (the 12 months immediately preceding entry into the FSP) and the follow-up is limited to one year, the totals for “number of days” are equivalent.

**Change** – The “change” columns show the movement from baseline to partnership (partnership minus baseline).

**Change in %** – The “change in %” parameter standardizes the percentages. These are used in the graph.

**Graph** – The graphs show the relative change in percentage of housing days by category, from baseline to partnership. Most categories to the left of center are considered favorable, and percentages above the 0% line reflect positive outcomes. Less stable residential settings generally fall to the right, and measurements below the 0% line indicate positive outcomes.

NOTE: “MHSA stabilization” housing is a program, unique to San Francisco, through which clients can be placed in an SRO unit for 60 days, to allow a partner to accumulate housing history while applying for permanent housing.
### Change in Percentage of Residential Days

<table>
<thead>
<tr>
<th>Residential Category</th>
<th>Baseline # Clients</th>
<th>Baseline Days</th>
<th>Baseline % of Total Days</th>
<th>Partnership # Clients</th>
<th>Partnership Days</th>
<th>Partnership % of Total Days</th>
<th>Change in Days</th>
<th>Change in % of Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Living</td>
<td>64</td>
<td>14,836</td>
<td>13.0%</td>
<td>66</td>
<td>14,368</td>
<td>12.6%</td>
<td>-468</td>
<td>-3%</td>
</tr>
<tr>
<td>Supervised Placement</td>
<td>28</td>
<td>4,577</td>
<td>4.0%</td>
<td>29</td>
<td>6,620</td>
<td>6.0%</td>
<td>2,043</td>
<td>20%</td>
</tr>
<tr>
<td>Residential Tx</td>
<td>83</td>
<td>7,292</td>
<td>6.4%</td>
<td>83</td>
<td>9,313</td>
<td>8.2%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>SRO with Lease</td>
<td>141</td>
<td>38,207</td>
<td>33.6%</td>
<td>196</td>
<td>52,137</td>
<td>45.8%</td>
<td>13,930</td>
<td>36%</td>
</tr>
<tr>
<td>Stabilization</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>53</td>
<td>5,627</td>
<td>4.9%</td>
<td>53</td>
<td>NA</td>
</tr>
<tr>
<td>Shelter/Temp Housing</td>
<td>94</td>
<td>14,829</td>
<td>13.0%</td>
<td>72</td>
<td>10,860</td>
<td>9.5%</td>
<td>-22</td>
<td>-27%</td>
</tr>
<tr>
<td>Homeless</td>
<td>103</td>
<td>18,124</td>
<td>15.9%</td>
<td>63</td>
<td>7,193</td>
<td>6.3%</td>
<td>-10,931</td>
<td>-60%</td>
</tr>
<tr>
<td>Justice System</td>
<td>72</td>
<td>8,394</td>
<td>7.4%</td>
<td>56</td>
<td>4,794</td>
<td>4.2%</td>
<td>-3,600</td>
<td>-43%</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>105</td>
<td>4,320</td>
<td>3.8%</td>
<td>57</td>
<td>2,185</td>
<td>1.9%</td>
<td>-48</td>
<td>-49%</td>
</tr>
<tr>
<td>Other/Unknown Resid</td>
<td>19</td>
<td>3,301</td>
<td>2.9%</td>
<td>8</td>
<td>583</td>
<td>0.5%</td>
<td>-2,718</td>
<td>-82%</td>
</tr>
<tr>
<td><strong>Total UDC</strong></td>
<td><strong>312</strong></td>
<td><strong>113,880</strong></td>
<td></td>
<td><strong>312</strong></td>
<td><strong>113,880</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
1. Includes all clients with at least one year in the partnership, where the initial year of partnership was uninterrupted. Both active and inactive clients are included.
2. The baseline year is based on the "Past 12 Months" residential question in the PAF residential domain.
3. The partnership year is based on the "today" selection in the PAF residential domain, and subsequent KETs with residential changes.
4. The "# clients" column is an unduplicated client count within each residential category and in the total. However, clients may be duplicated across categories, so the counts for the individual categories will usually be greater than the total. However, clients may be duplicated across categories, so the counts for the individual categories will usually be greater than the total.
5. Clients who transfer between FSPs have their entire history listed under their most recent FSP.

DCR Data as of 7/18/11
### DCR Residential Followup Report

**Baseline Year Compared to First Year in Partnership**

**for Age Group CHILD**

<table>
<thead>
<tr>
<th>Residential Category</th>
<th>Baseline</th>
<th></th>
<th>Partnership</th>
<th></th>
<th>Change</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># Clients</td>
<td>Days (Total)</td>
<td># Clients</td>
<td>Days (Total)</td>
<td>#</td>
<td>Days as % of Baseline</td>
</tr>
<tr>
<td>------------------------------</td>
<td>----------</td>
<td>------------------</td>
<td>-------------</td>
<td>------------------</td>
<td>--------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Rent/Own Housing</td>
<td>1</td>
<td>30 (0.1%)</td>
<td>0</td>
<td>0 (0.0%)</td>
<td>-1</td>
<td>-30 (-100%)</td>
</tr>
<tr>
<td>With Parents</td>
<td>54</td>
<td>12,017 (24.4%)</td>
<td>51</td>
<td>16,483 (33.5%)</td>
<td>-3</td>
<td>4,466 (37%)</td>
</tr>
<tr>
<td>With Other Family</td>
<td>22</td>
<td>3,820 (7.8%)</td>
<td>13</td>
<td>3,033 (6.2%)</td>
<td>-9</td>
<td>-787 (-21%)</td>
</tr>
<tr>
<td>Foster Home Relative</td>
<td>25</td>
<td>5,618 (11.4%)</td>
<td>26</td>
<td>8,021 (16.3%)</td>
<td>1</td>
<td>2,403 (43%)</td>
</tr>
<tr>
<td>Foster Home Non-relative</td>
<td>53</td>
<td>10,031 (20.4%)</td>
<td>50</td>
<td>14,818 (30.1%)</td>
<td>-3</td>
<td>4,787 (48%)</td>
</tr>
<tr>
<td>Residential Tx</td>
<td>59</td>
<td>16,346 (33.2%)</td>
<td>35</td>
<td>5,511 (11.2%)</td>
<td>-24</td>
<td>-10,835 (-66%)</td>
</tr>
<tr>
<td>Shelter/Temp Housing</td>
<td>7</td>
<td>89 (0.2%)</td>
<td>8</td>
<td>108 (0.2%)</td>
<td>1</td>
<td>19 (21%)</td>
</tr>
<tr>
<td>Justice System</td>
<td>10</td>
<td>228 (0.5%)</td>
<td>17</td>
<td>451 (0.9%)</td>
<td>7</td>
<td>223 (98%)</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>14</td>
<td>209 (0.4%)</td>
<td>6</td>
<td>62 (0.1%)</td>
<td>-8</td>
<td>-147 (-70%)</td>
</tr>
<tr>
<td>Other/Unknown Resid</td>
<td>10</td>
<td>887 (1.8%)</td>
<td>11</td>
<td>788 (1.6%)</td>
<td>1</td>
<td>-99 (-11%)</td>
</tr>
<tr>
<td>Total UDC</td>
<td>135</td>
<td>49,275</td>
<td>135</td>
<td>49,275</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Change in Percentage of Residential Days

![Change in Percentage of Residential Days](image)

**Notes**

1. Includes all clients with at least one year in the partnership, where the initial year of partnership was uninterrupted. Both active and inactive clients are included.
2. The baseline year is based on the "Past 12 Months" residential question in the PAF residential domain.
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5. Clients who transfer between FSPs have their entire history listed under their most recent FSP.
### DCR Residential Followup Report
*Baseline Year Compared to First Year in Partnership for Age Group OA*

<table>
<thead>
<tr>
<th>Residential Category</th>
<th>Baseline # Clients</th>
<th># Days</th>
<th>% of Total Days</th>
<th>Partnership # Clients</th>
<th># Days</th>
<th>% of Total Days</th>
<th>Change Days as % of Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Living</td>
<td>23</td>
<td>7,394</td>
<td>42.2%</td>
<td>23</td>
<td>6,089</td>
<td>34.8%</td>
<td>-1,305 -18%</td>
</tr>
<tr>
<td>Supervised Placement</td>
<td>3</td>
<td>403</td>
<td>2.3%</td>
<td>6</td>
<td>1,139</td>
<td>6.5%</td>
<td>3 736 183%</td>
</tr>
<tr>
<td>Residential Tx</td>
<td>2</td>
<td>198</td>
<td>1.1%</td>
<td>2</td>
<td>405</td>
<td>2.3%</td>
<td>0 207 105%</td>
</tr>
<tr>
<td>SRO with Lease</td>
<td>6</td>
<td>1,585</td>
<td>9.0%</td>
<td>11</td>
<td>2,673</td>
<td>15.3%</td>
<td>5 1,088 69%</td>
</tr>
<tr>
<td>Stabilization</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>2</td>
<td>730</td>
<td>4.2%</td>
<td>2 730 NA</td>
</tr>
<tr>
<td>Shelter/Temp Housing</td>
<td>15</td>
<td>3,261</td>
<td>18.6%</td>
<td>13</td>
<td>2,806</td>
<td>16.0%</td>
<td>-2 455 -14%</td>
</tr>
<tr>
<td>Homeless</td>
<td>8</td>
<td>1,500</td>
<td>8.6%</td>
<td>5</td>
<td>874</td>
<td>5.0%</td>
<td>-3 626 -42%</td>
</tr>
<tr>
<td>Justice System</td>
<td>2</td>
<td>125</td>
<td>0.7%</td>
<td>2</td>
<td>59</td>
<td>0.3%</td>
<td>0 66 -53%</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>15</td>
<td>690</td>
<td>3.9%</td>
<td>10</td>
<td>935</td>
<td>5.3%</td>
<td>-5 245 36%</td>
</tr>
<tr>
<td>Other/Unknown Resid</td>
<td>10</td>
<td>2,364</td>
<td>13.5%</td>
<td>10</td>
<td>1,810</td>
<td>10.3%</td>
<td>-5 554 -23%</td>
</tr>
<tr>
<td><strong>Total UDC</strong></td>
<td><strong>48</strong></td>
<td><strong>17,520</strong></td>
<td></td>
<td><strong>48</strong></td>
<td><strong>17,520</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Change in Percentage of Residential Days**

<table>
<thead>
<tr>
<th>Residential Category</th>
<th>Change in Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Living</td>
<td>24</td>
</tr>
<tr>
<td>Supervised Placement</td>
<td>-15</td>
</tr>
<tr>
<td>Residential Tx</td>
<td>15</td>
</tr>
<tr>
<td>SRO with Lease</td>
<td>-15</td>
</tr>
<tr>
<td>Stabilization</td>
<td>-5</td>
</tr>
<tr>
<td>Shelter/Temp Housing</td>
<td>15</td>
</tr>
<tr>
<td>Homeless</td>
<td>15</td>
</tr>
<tr>
<td>Justice System</td>
<td>-4</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>15</td>
</tr>
<tr>
<td>Other/Unknown Resid</td>
<td>15</td>
</tr>
</tbody>
</table>

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DCR Data as of 7/18/11
### DCR Residential Followup Report

#### Baseline Year Compared to First Year in Partnership for Age Group TAY

<table>
<thead>
<tr>
<th>Residential Category</th>
<th>Baseline</th>
<th></th>
<th>Partnership</th>
<th></th>
<th>Change</th>
<th>Change in % of Total Days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># Clients</td>
<td>Days</td>
<td>% of Total Days</td>
<td># Clients</td>
<td>Days</td>
<td>% of Total Days</td>
</tr>
<tr>
<td>General Living</td>
<td>45</td>
<td>11,408</td>
<td>50.4%</td>
<td>39</td>
<td>10,709</td>
<td>47.3%</td>
</tr>
<tr>
<td>Supervised Placement</td>
<td>4</td>
<td>895</td>
<td>4.0%</td>
<td>9</td>
<td>1,923</td>
<td>8.5%</td>
</tr>
<tr>
<td>Residential Tx</td>
<td>24</td>
<td>2,964</td>
<td>13.1%</td>
<td>19</td>
<td>2,444</td>
<td>10.8%</td>
</tr>
<tr>
<td>SRO with Lease</td>
<td>5</td>
<td>554</td>
<td>2.4%</td>
<td>18</td>
<td>3,579</td>
<td>15.8%</td>
</tr>
<tr>
<td>Stabilization</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>2</td>
<td>352</td>
<td>1.6%</td>
</tr>
<tr>
<td>Shelter/Temp Housing</td>
<td>15</td>
<td>2,059</td>
<td>9.1%</td>
<td>14</td>
<td>2,013</td>
<td>8.9%</td>
</tr>
<tr>
<td>Homeless</td>
<td>8</td>
<td>1,412</td>
<td>6.2%</td>
<td>2</td>
<td>228</td>
<td>1.0%</td>
</tr>
<tr>
<td>Justice System</td>
<td>10</td>
<td>1,344</td>
<td>5.9%</td>
<td>7</td>
<td>221</td>
<td>1.0%</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>26</td>
<td>1,489</td>
<td>6.6%</td>
<td>18</td>
<td>835</td>
<td>3.7%</td>
</tr>
<tr>
<td>Other/Unknown Resid</td>
<td>4</td>
<td>505</td>
<td>2.2%</td>
<td>4</td>
<td>326</td>
<td>1.4%</td>
</tr>
<tr>
<td><strong>Total UDC</strong></td>
<td>62</td>
<td>22,630</td>
<td>62</td>
<td>22,630</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Change in Percentage of Residential Days**

#### Notes

1. Includes all clients with at least one year in the partnership, where the initial year of partnership was uninterrupted. Both active and inactive clients are included.
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DCR Data as of 7/18/11  
Page 4 of 5
# Child Residential Category Definitions

<table>
<thead>
<tr>
<th>Category</th>
<th>Residential Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster Home Non-relative</td>
<td>Foster Home Non-relative</td>
</tr>
<tr>
<td>Foster Home Relative</td>
<td>Foster Home Relative</td>
</tr>
<tr>
<td>Homeless</td>
<td>Homeless</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>Medical Hospital</td>
</tr>
<tr>
<td></td>
<td>Psychiatric Hospital</td>
</tr>
<tr>
<td></td>
<td>State Psychiatric</td>
</tr>
<tr>
<td>Justice System</td>
<td>Juvenile Hall / Camp</td>
</tr>
<tr>
<td></td>
<td>DJJ</td>
</tr>
<tr>
<td></td>
<td>Prison</td>
</tr>
<tr>
<td></td>
<td>Jail</td>
</tr>
<tr>
<td>NA</td>
<td>Single Room Occupancy</td>
</tr>
<tr>
<td></td>
<td>Individual Placement</td>
</tr>
<tr>
<td></td>
<td>Congregate Placement</td>
</tr>
<tr>
<td></td>
<td>Community Care</td>
</tr>
<tr>
<td></td>
<td>Long-Term Care</td>
</tr>
<tr>
<td></td>
<td>Assisted Living</td>
</tr>
<tr>
<td>Other/Unknown Resid</td>
<td>MHSA Stabilization Unit</td>
</tr>
<tr>
<td>Rent/Own Housing</td>
<td>Other Setting</td>
</tr>
<tr>
<td></td>
<td>Unknown Setting</td>
</tr>
<tr>
<td>Residential Tx</td>
<td>Rent/Own Housing</td>
</tr>
<tr>
<td></td>
<td>Group Home 0-11</td>
</tr>
<tr>
<td></td>
<td>Group Home 12-14</td>
</tr>
<tr>
<td></td>
<td>Community Treatment</td>
</tr>
<tr>
<td></td>
<td>Residential Treatment</td>
</tr>
<tr>
<td></td>
<td>Nursing Physical</td>
</tr>
<tr>
<td></td>
<td>Nursing Psychiatric</td>
</tr>
<tr>
<td>Shelter/Temp Housing</td>
<td>Shelter/Temporary Housing</td>
</tr>
<tr>
<td>With Other Family</td>
<td>With Other Family</td>
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<tr>
<td>With Parents</td>
<td>With Parents</td>
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</tbody>
</table>

# Adult Residential Category Definitions

(includes TAY, Adult and Older Adult)

<table>
<thead>
<tr>
<th>Category</th>
<th>Residential Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Living</td>
<td>With Parents</td>
</tr>
<tr>
<td></td>
<td>With Other Family</td>
</tr>
<tr>
<td></td>
<td>Rent/Own Housing</td>
</tr>
<tr>
<td></td>
<td>Foster Home Relative</td>
</tr>
<tr>
<td></td>
<td>Foster Home Non-relative</td>
</tr>
<tr>
<td>Homeless</td>
<td>Homeless</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>Medical Hospital</td>
</tr>
<tr>
<td></td>
<td>Psychiatric Hospital</td>
</tr>
<tr>
<td></td>
<td>State Psychiatric</td>
</tr>
<tr>
<td>Justice System</td>
<td>Juvenile Hall / Camp</td>
</tr>
<tr>
<td></td>
<td>DJJ</td>
</tr>
<tr>
<td></td>
<td>Prison</td>
</tr>
<tr>
<td></td>
<td>Jail</td>
</tr>
<tr>
<td>Other/Unknown Resid</td>
<td>Other Setting</td>
</tr>
<tr>
<td></td>
<td>Unknown Setting</td>
</tr>
<tr>
<td>Residential Tx</td>
<td>Group Home 0-11</td>
</tr>
<tr>
<td></td>
<td>Group Home 12-14</td>
</tr>
<tr>
<td></td>
<td>Community Treatment</td>
</tr>
<tr>
<td></td>
<td>Residential Treatment</td>
</tr>
<tr>
<td></td>
<td>Nursing Physical</td>
</tr>
<tr>
<td></td>
<td>Nursing Psychiatric</td>
</tr>
<tr>
<td></td>
<td>Long-Term Care</td>
</tr>
<tr>
<td>Shelter/Temp Housing</td>
<td>Shelter/Temporary Housing</td>
</tr>
<tr>
<td>SRO with Lease</td>
<td>Single Room Occupancy</td>
</tr>
<tr>
<td>Stabilization</td>
<td>MHSA Stabilization Unit</td>
</tr>
<tr>
<td>Supervised Placement</td>
<td>Individual Placement</td>
</tr>
<tr>
<td></td>
<td>Congregate Placement</td>
</tr>
<tr>
<td></td>
<td>Community Care</td>
</tr>
<tr>
<td></td>
<td>Assisted Living</td>
</tr>
</tbody>
</table>
FSP Report – Ventura County

Ventura County Behavioral Health (VCBH)

Report audience(s): VCBH managers, clinic administrators

Source(s) of data: California Department of Mental Health – Information Technology Web Services (ITWS) Mental Health Services Act (MHSA) Data Collection and Reporting (DCR) System; Full Service Partnership Data (FSP)

Report schedule: Quarterly

Report background:

The Ventura County Behavioral Health (VCBH) Full Service Partnership (FSP) reports are distributed quarterly to division and program managers for regular evaluation of trends in client and program characteristics tracked by the FSP measures. The standard reports aggregate data collected within a reporting period, by program, and display summaries of the most salient and typically completed data points. The reports allow the audience to use the data in conjunction with existing information about the program from an operations and stakeholder perspective; to evaluate the progress of the program over time; and to construct a narrative of their own, if desired. Reports also may be run to generate summaries for other specified periods of time, such as fiscal years, and could be further modified to aggregate data across groups of programs, or be tailored to home in on interactions between key variables.

Report development and technical specifications:

The diagram here shows that one report per data source is available from the California Department of Mental Health ITWS MHSA DCR System.

Data is collected and uploaded to ITWS:
- 3 Forms: PAF, Key Event, Quarterly
- 4 Age Groups: Child, TAY, Adult, Older
- Adult = 12 Forms Total

Data is downloaded from ITWS MHSA DCR:
- PAF with Residential, PAF without Residential, Key Event, Quarterly
- = 4 Excel Files (CSV Format)

Reports Developed to Summarize Data Downloads:
- PAF with Residential, PAF without Residential, Key Event, Quarterly
- = 4 Crystal Reports*
*In comparison to standard statistical analysis or data presentation software (such as Microsoft Excel or SPSS), Crystal Reports software requires more time for initial report development and is not intended for in-depth statistical analysis; however, for recurring reports highlighting summary statistics and basic indicators of change, it is more time efficient in the long run. Crystal Reports greatly reduces the time required for the production of identical reports. Additionally, depending on the report’s design, commonly requested modifications are easier to make in Crystal Reports.

To run the reports, data for one measure is downloaded from the ITWS MHSA DCR System and imported into a Microsoft Access database table built especially to hold that data set. The corresponding FSP Crystal Report is attached to the table of data. The report is “refreshed” and typically exported into an easy-to-use Adobe PDF document for distribution. The Access database is used as an intermediary between the Excel file and the Crystal Reports file to ensure that each data point is treated as the appropriate variable type for the report. An outline of the full procedure can be obtained by contacting the lead report developer:

Rajima Danish
Quality Improvement Project Manager
Rajima.Danish@Ventura.org
The following opinion published in Capitol Weekly refers to the FSP report above.

**Opinion: Prop. 63 critics miss the mark entirely**

By Marvin Southard | Sept. 1, 2011

By the early part of this decade, 30 years of underfunding had left California’s mental health system in tatters. Dollars were available to serve only half those in need of services. In this crisis-driven system, individuals too often reached a crisis point before receiving care, resulting in a chronic cycle of homelessness, institutionalization, or incarceration.

Voters sought to change this costly system and improve its effectiveness when they passed Prop. 63 in 2004 – providing funding designated to increase delivery of proven services to those with severe mental illness. Recognizing that reducing homelessness and incarceration – and dollars spent on institutionalization – requires taking the long view, MHSA also identified prevention and early intervention as key priorities.

Results show that 528,424 people with mental illness or serious emotional disturbance have been served by MHSA-funded programs since 2006, and those in crisis are more likely to find the help they need in cost-effective community services rather than costly settings like jails and institutions.

So it is concerning to read the authors of the Capitol Weekly opinion submission “In California’s System of Care for the Mentally Ill, Leadership Is Lacking” advocate for a return to a system which serves only a fraction of the population in need, and only then in the most costly settings.

The authors are flat-out wrong when they say the MHSA hasn’t helped those with severe mental illness. In fact, the largest component of the MHSA is a group of comprehensive and intensive service programs called full service partnerships (FSP). These programs serve mentally ill individuals who have recent histories of homelessness, multiple incarcerations, and hospitalizations, and children in foster care placements.

In Los Angeles County, FSP programs are currently serving 6,256 individuals of all ages, and the results speak for themselves. Recent data show severely mentally ill adults enrolled in an
FSP program have experienced the following:

- 68% reduction in days spent homeless
- 53% increase in days living independently
- 46% reduction in days incarcerated
- 23% decrease in days psychiatrically hospitalized

What’s more, by serving people with mental illness in community settings, the MHSA saves money. A May 2010 analysis showed enrolling Los Angeles County adults and seniors in FSP programs saved $39 million that would otherwise have been spent on psychiatric hospitalizations and incarcerations.

The MHSA recognizes that there is no one-size-fits-all solution to supporting people with mental illness in their recovery. After a series of comprehensive community meetings and workgroups composed of stakeholders from all walks of life that informed five plans approved by the state, Los Angeles County has implemented community services and supports to support mentally ill individuals in crisis, and avert, where possible, more expensive and restrictive psychiatric hospitalizations and inappropriate use of emergency departments.

These include clinical services provided in the field, wellness centers to help individuals stay on track with their recovery, and drop-in centers to engage and educate individuals who have signs or symptoms of mental illness about the importance of mental health treatment. Because employment is an essential part of recovery for many with mental illness, employment services constitute an important component of many MHSA-funded programs.

As is so often said about our community’s physical health, prevention is truly the best medicine when it comes to treating mental illness. That’s why Los Angeles and other counties have prioritized services that reach those in need before they reach the crisis point. Suicide hotlines, reducing school violence, and reducing the stigma associated with mental illness are all parts of a comprehensive plan to increase the number of clients who seek mental health services for themselves or their family members before they reach the streets or prison.

Just as it wouldn’t make sense to shut down a whole hospital and only leave open the emergency room, a mental health system which serves only those currently in crisis wouldn’t fulfill the mandate the voters gave us to keep Californians from reaching the crisis point.

Unfortunately, the state’s ongoing budgetary crisis has delivered severe setbacks to our efforts to meet the voters’ mandate to significantly expand mental health services. The recession has forced more than $1 billion in cuts to state mental health programs over the past three years and left the safety net too damaged to serve all those in need.

Nevertheless, MHSA services have improved the lives of many in our community and are an essential part of counties’ efforts to address the mental health needs of those in our community who need our support.
## County of Los Angeles – Department of Mental Health

Program Support Bureau – MHSA Implementation Unit

Annualized Living Arrangement Summary By Program

**Program: FSP – Adult**

<table>
<thead>
<tr>
<th>Residential Type Cluster</th>
<th>Residential Type Description</th>
<th>Pre-Partnership (Baseline)</th>
<th>Total Days</th>
<th>Average Days</th>
<th>Number of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute psychiatric hospital or PHF</td>
<td>Acute psychiatric hospital or Psychiatric health facility (PHF)</td>
<td></td>
<td>79,130</td>
<td>51.1</td>
<td>1,548</td>
</tr>
<tr>
<td>Acute psychiatric hospital or PHF</td>
<td></td>
<td></td>
<td>79,130</td>
<td>51.1</td>
<td>1,548</td>
</tr>
<tr>
<td>Assisted living</td>
<td>Assisted living facility</td>
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<td>3,447</td>
<td>156.7</td>
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<tr>
<td>Unlicensed but supervised individual placement</td>
<td></td>
<td></td>
<td>10,889</td>
<td>153.4</td>
<td>71</td>
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<tr>
<td>Assisted living</td>
<td>Licensed community care facility (board and care)</td>
<td></td>
<td>14,336</td>
<td>154.2</td>
<td>93</td>
</tr>
<tr>
<td>Board and care</td>
<td></td>
<td></td>
<td>156,232</td>
<td>183.2</td>
<td>853</td>
</tr>
<tr>
<td>Assisted living</td>
<td>Licensed community care facility (board and care)</td>
<td></td>
<td>156,232</td>
<td>183.2</td>
<td>853</td>
</tr>
<tr>
<td>Board and care</td>
<td></td>
<td></td>
<td>156,232</td>
<td>183.2</td>
<td>853</td>
</tr>
<tr>
<td>Congregate living</td>
<td>Group living home</td>
<td></td>
<td>13,515</td>
<td>150.2</td>
<td>90</td>
</tr>
<tr>
<td>Sober living home</td>
<td></td>
<td></td>
<td>36,965</td>
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<td>Congregate living</td>
<td>Emergency shelter</td>
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<td>50,480</td>
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<td></td>
<td>86,194</td>
<td>144.1</td>
<td>598</td>
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<tr>
<td>Emergency shelter</td>
<td></td>
<td></td>
<td>86,194</td>
<td>144.1</td>
<td>598</td>
</tr>
<tr>
<td>Homeless</td>
<td></td>
<td>Homeless (includes people living in cars)</td>
<td>535,074</td>
<td>246.4</td>
<td>2,172</td>
</tr>
<tr>
<td>Homeless</td>
<td></td>
<td></td>
<td>535,074</td>
<td>246.4</td>
<td>2,172</td>
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<tr>
<td>Hospitalization or institutionalization</td>
<td>Institution for mental disease (IMD)</td>
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<td>79,471</td>
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<td>Hospitalization or institutionalization</td>
<td>Mental health rehabilitation center (MHRC)</td>
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<td>9,128</td>
<td>163.0</td>
<td>56</td>
</tr>
<tr>
<td>Hospitalization or institutionalization</td>
<td>Skilled nursing facility (SNF) – psychiatric</td>
<td></td>
<td>3,832</td>
<td>141.9</td>
<td>27</td>
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<tr>
<td>Hospitalization or institutionalization</td>
<td>State psychiatric hospital</td>
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<td>17,998</td>
<td>166.6</td>
<td>108</td>
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<tr>
<td>Hospitalization or institutionalization</td>
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<td>Lives in an apartment or house</td>
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<td>Single-room occupancy (SRO) – must hold lease</td>
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<td>21,956</td>
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<td>119</td>
</tr>
<tr>
<td>Independent living</td>
<td></td>
<td></td>
<td>304,839</td>
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<td>Justice facilities</td>
<td>Jail</td>
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<td>101,718</td>
<td>111.8</td>
<td>910</td>
</tr>
<tr>
<td>Justice facilities</td>
<td>Prison</td>
<td></td>
<td>5,592</td>
<td>164.5</td>
<td>34</td>
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<tr>
<td>Justice facilities</td>
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<tr>
<td>Living with family</td>
<td>Lives with adult family members other than parents – non-foster care</td>
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<td>130,369</td>
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<tr>
<td>Living with family</td>
<td>Lives with one or both biological or adoptive parents</td>
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<td>163,347</td>
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<td>718</td>
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<tr>
<td>Living with family</td>
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<td></td>
<td>293,716</td>
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<tr>
<td>Medical or physical health settings</td>
<td>Acute medical hospital</td>
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<td>9,951</td>
<td>30.7</td>
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<tr>
<td>Medical or physical health settings</td>
<td>Skilled nursing facility (SNF) – physical</td>
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<td>4,456</td>
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</tr>
<tr>
<td>Medical or physical health settings</td>
<td></td>
<td></td>
<td>14,407</td>
<td>40.6</td>
<td>355</td>
</tr>
</tbody>
</table>

[Table continues on next page]
<table>
<thead>
<tr>
<th>Residential Type Description</th>
<th>Annualized Total Days</th>
<th>Average Days</th>
<th>Number of Clients</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute psychiatric hospital or PHF</td>
<td>61,291.8</td>
<td>48.07</td>
<td>1,275</td>
<td>-23%</td>
</tr>
<tr>
<td>Assisted living</td>
<td>7,446.6</td>
<td>155.14</td>
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<tr>
<td>Unlicensed but supervised individual placement</td>
<td>17,245.4</td>
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<td>Assisted living</td>
<td>24,692.0</td>
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<td>72%</td>
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<tr>
<td>Board and care</td>
<td>297,742.5</td>
<td>221.86</td>
<td>1,342</td>
<td>91%</td>
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<tr>
<td>Group living home</td>
<td>17,531.1</td>
<td>113.10</td>
<td>155</td>
<td>30%</td>
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<tr>
<td>Sober living home</td>
<td>86,830.2</td>
<td>147.92</td>
<td>587</td>
<td>135%</td>
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<tr>
<td>Congregate living</td>
<td>104,361.3</td>
<td>140.6</td>
<td>742</td>
<td>107%</td>
</tr>
<tr>
<td>Emergency shelter</td>
<td>85,554.9</td>
<td>115.30</td>
<td>742</td>
<td>-1%</td>
</tr>
<tr>
<td>Homeless</td>
<td>173,486.7</td>
<td>138.57</td>
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<td>-68%</td>
</tr>
<tr>
<td>Institution for mental disease (IMD)</td>
<td>6,426.9</td>
<td>97.38</td>
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<td>-92%</td>
</tr>
<tr>
<td>Mental health rehabilitation center (MHRC)</td>
<td>1,498.5</td>
<td>124.88</td>
<td>12</td>
<td>-84%</td>
</tr>
<tr>
<td>Skilled nursing facility (SNF) – psychiatric</td>
<td>2,593.8</td>
<td>66.51</td>
<td>39</td>
<td>-32%</td>
</tr>
<tr>
<td>State psychiatric hospital</td>
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<td>27.98</td>
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<td>-94%</td>
</tr>
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<td>Hospitalization or institutionalization</td>
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<td>75.3</td>
<td>153</td>
<td>-90%</td>
</tr>
<tr>
<td>Lives in an apartment or house</td>
<td>427,513.1</td>
<td>275.64</td>
<td>1,551</td>
<td>51%</td>
</tr>
<tr>
<td>Single-room occupancy (SRO) – must hold lease</td>
<td>40,007.7</td>
<td>173.19</td>
<td>231</td>
<td>82%</td>
</tr>
<tr>
<td>Independent living</td>
<td>467,520.8</td>
<td>262.4</td>
<td>1,782</td>
<td>53%</td>
</tr>
<tr>
<td>Jail</td>
<td>56,817.5</td>
<td>81.52</td>
<td>697</td>
<td>-44%</td>
</tr>
<tr>
<td>Prison</td>
<td>846.0</td>
<td>65.08</td>
<td>13</td>
<td>-85%</td>
</tr>
<tr>
<td>Justice facilities</td>
<td>57,663.5</td>
<td>81.2</td>
<td>710</td>
<td>-46%</td>
</tr>
<tr>
<td>Lives with adult family members other than parents – non-foster care</td>
<td>122,181.3</td>
<td>187.97</td>
<td>650</td>
<td>-6%</td>
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<tr>
<td>Lives with one or both biological or adoptive parents</td>
<td>162,790.7</td>
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<td>698</td>
<td>0%</td>
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<tr>
<td>Living with family</td>
<td>284,972.0</td>
<td>211.4</td>
<td>1,348</td>
<td>-3%</td>
</tr>
<tr>
<td>Acute medical hospital</td>
<td>23,812.7</td>
<td>38.66</td>
<td>616</td>
<td>139%</td>
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<tr>
<td>Skilled nursing facility (SNF) – physical</td>
<td>9,847.4</td>
<td>96.54</td>
<td>102</td>
<td>121%</td>
</tr>
<tr>
<td>Medical or physical health settings</td>
<td>33,660.0</td>
<td>46.9</td>
<td>718</td>
<td>134%</td>
</tr>
</tbody>
</table>
MHSA Report – TAY Living Situation, Santa Clara County

TAPIS Tracking

The Transition to Adulthood Program Information System (TAPIS) helps young people and their transition personnel track the progress and difficulties that youth and young adults (ages 14–29 years) experience during their transition to assuming adulthood roles. The TAPIS includes “goal achiever” and a “progress tracker” elements. The “goal achiever” component helps young people set and track their own individualized goals that may include several measurable objectives; each objective consists of discrete steps toward goal achievement, with assignments regarding involved persons and target dates for each goal. The “progress tracker” component assesses, on a quarterly basis, a young person’s progress and/or difficulty in transition across five transition domains: employment, education, living situation, personal effectiveness and well-being, and community-life functioning.

The TAPIS was developed by the National Network on Youth Transition for Behavioral Health (NNYT) and computerized by the Mosaic Network, Inc., into an integrated system. It enables personnel to access relevant data reports for their direct service delivery work, supervisory responsibilities, program management decisions, and evaluation activities.

The NNYT now has two hubs – one at the University of South Florida (USF) in Tampa, FL, and one at Stars Behavioral Health Group (SBHG) in Long Beach, CA. The SBHG Stars Training Academy serves as the official NNYT purveyor to assist agencies and communities in the implementation of the transition to independence process (TIP) model for improving the outcomes of youth and young adults. Both USF and SBHG are involved in evaluation and continuing quality improvement activities related to transition to adulthood.

For more information about TIP, TIP evaluation, and the TAPIS, visit:

- TAPIS: [http://mosaic-network.com](http://mosaic-network.com)
- TIP training and fidelity assessment: [http://NNYT.TIPstars.org](http://NNYT.TIPstars.org)
Reporting Living Situation for TAY

This sample application of exported MHSA data from Santa Clara County to a private provider is an examination of one specific indicator area (stability/type of living situations). This analysis was part of an initial assessment of the implementation of a program model (transition to independence process or TIP). Other indicator areas are being assessed, as well as further periods related to stage of model implementation (in an agency that since then has been TIP-certified). The report, which was for a continuous quality improvement (CQI) council, contains baseline information on living situations, including placement changes or occurrences, days per setting type, and status at intake versus discharge. The first two graphs show both central tendencies and highlight outliers (e.g., clients with many placement changes). Then, cohorts are drawn using simple descriptive statistics. Importantly, these data do not “stand alone” – the analysis also contains comparisons of Global Assessment of Functioning (GAF) score changes, discharge reasons, and extent of treatment goals met across the cohorts. The trend for all these data was positive, strengthening the hypothesis that the TIP model benefits young adult outcomes. At the same time, the team received suggestions about ways to improve their data collection and data entry practices to assure accurate and complete data sets.
MHSA Baseline Data – Living Situations

60 Starlight FSP TAY Served Since Program Start thru June 2010, Incl. Active Clients

Occurrences Over Twelve Months Before FSP

- Mean
- Maximum

Total Occurrences In Year:
- Range = 1 to 35
- Avg = 4; Median = 3
- % w/ > One = 85%

% w/ One or More In Year:
- 85% Living w/ Family
- 3% Living Independently
- 8% Homeless/Shelter
- 5% Supv. Placement
- 10% Psych Hospital
- 23% Res/Tx/Group Home
- 60% Criminal Justice
- 7% Other Settings

% At Time of Enrollment:
- 67% Living w/ Family
- 5% Supv. Placement
- 3% Psych Hospital
- 21% Res/Tx/Group Home
- 4% Criminal Justice
### Starlight’s TIP Implementation…

#### Initial Cohorts …Living Situation

<table>
<thead>
<tr>
<th><strong>MHSA Data</strong></th>
<th><strong>Cohort I: Discharged Before or During Year One</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>TIP Academy Training (N=19)</strong></td>
</tr>
<tr>
<td><strong>ENROLLMENT</strong></td>
<td><strong>DISCHARGE</strong></td>
</tr>
<tr>
<td>Point in Time Settings</td>
<td>50% Family 11% Supv. Plcmnt 33% Restx/GH 6% UNKNOWN</td>
</tr>
<tr>
<td>Total Setting Counts in a Year</td>
<td>1 to 35 Avg = 5.9 % &gt; 1 = 88%</td>
</tr>
<tr>
<td>Monthly Rate of Settings</td>
<td>Avg = .50 Median = .33</td>
</tr>
</tbody>
</table>

| **Cohort II: Discharged During Year Two** |
| **TIP Academy (N=23)**               |
| **ENROLLMENT** | **DISCHARGE**                                 |
| 56% Family 9% Acute Hosp 22% Restx/GH 9% UNKNOWN |
| 1 to 10 Avg = 3.3 % > 1 = 86% |
| Avg = .28 Median = .25 |

TIP Yr Two Post ANOVA Comparison to Yr One: Setting Counts, p.<.03; Monthly Rate, p.<.004
TIP Yr Two Enrollment to Discharge Matched Pairs: Setting Counts, p.<.004; Monthly Rate p.<.038

#### Starlight’s TIP Implementation

**Initial Cohort Analyses -- Stability of Living Situations**

![Bar chart showing stability of living situations](chart)

- Total Setting Counts in One Year
- Monthly Rate of Setting Changes
Figure 1

The data show that in March 2011, four clients were rated “1” (extreme risk), which was one more than the number of people with that rating in March 2010. The data also indicate that three clients were rated “2” (high risk, not engaged) in March 2011, one fewer than the number of people with that rating in March 2010. The reports show that 21 clients were rated “3” (high risk, engaged) in March 2011, an increase of four over the total for March 2010. The biggest decreases were in milestone 4 (not coping successfully, not engaged), which declined from 39 in March 2010 to just 10 in March 2011, and in milestone 5 (not coping successfully, engaged), which diminished from 151 in March 2010 to 123 in March 2011. The programs demonstrated a large increase in milestone 6 (coping successfully or rehabilitating), which rose from 136 to 166 clients. The biggest percentage increase was in milestone 7 (early recovery), which surged from 30 clients in March 2010 to 53 clients.
in March 2011, a 76% increase in the category. No clients attained milestone 8 (advanced recovery) at the time of either report.

The MORS also can be used to evaluate the average time required for a program or system to increase the level of recovery for the people it serves. Figure 2 shows the initial MORS rating and the MORS ratings at three, six and nine months after admission for 80 new clients who were admitted to MHALA’s Long Beach system of care between April 2010 and March 2011. The presentation was simplified in this Tool Kit by combining all the MORS ratings from 1 to 5 (“extreme risk” to “not coping successfully, engaged”) and those from 6 to 8 (“coping successfully, rehabilitating” to “advanced recovery”). The graph shows a steady decline in the percentage of clients “below the line” (MORS rating between 1 and 5) from 91% at admission to 42% at nine months after admission. It also shows a steady increase in the percentage of clients “above the line” (MORS rating between 6 and 8), from 9% at admission to 58% at nine months after admission.

Figure 2

The results in Figure 2 suggest that a client who enters MHALA’s Long Beach system of care will have a 50% chance of achieving a MORS rating of at least 6 (“coping successfully, rehabilitating”) within approximately eight months after admission. Of course, these examples are both at the program level, and could be disaggregated somewhat to show individual team outcomes within the program or rolled up even further to show aggregated results for multiple programs within a county system.
Recovery-Oriented Registry Example

This example describes a “recovery-oriented” registry that is based on data sources that have been mentioned in this Tool Kit, the FSP Data Collection and Reporting system and the Milestones of Recovery Scale (MORS). This registry was designed by Mental Health America of Los Angeles and is produced from data entered into MHALA’s electronic health record. It is intended to be printed out (but also can be viewed on a computer monitor) monthly for use in a supervisory session between a line staff member (John Doe) and his supervisor. The example, for the month of April 2011, consists entirely of imaginary data for illustrative purposes only. This Tool Kit describes only the MORS and Quality of Life sections in detail.

The first column shows the client’s name. The second column shows the client’s time in the current level of service (TILOS) – Charlie has been in the program for 12 years and 10 months. The next six columns reflect the client’s six most recent monthly MORS scores – in this case, from November 2010 through April 2011. For Charlie, these scores show a declining pattern over the previous six months, from 5 PC ENG (poorly coping, engaged) in November, to 4 PC NE (poorly coping, not engaged) in December, to 5 PC ENG (poorly coping, engaged) in January, to 3 HR ENG (high risk, engaged) in both February and March, and finally to 1 XRISK (extreme risk) in April 2011. Note that the different levels of the MORS are color-coded from green (6, 7, 8) to yellow (4, 5) to orange (2, 3) to red (1) to enable the reader to quickly determine the condition of a particular client.

Any outcome measure of interest to the staff and administration could be substituted for the MORS ratings used in this example. For example, the IMPACT program, which the University of Washington created and designed to reduce the symptoms of depression, uses the PHQ-9 to track the client’s scores on that instrument at the beginning of every encounter between the client and the clinician. The MORS is used here because the overall goal of FSPs is to increase the recovery of the clients they serve, but any similar measure of recovery could be used instead.

The “quality of life” section of the registry displays the client’s current FSP DCR data. For example, the column heading “RES STAT DATE” refers to the date of the client’s most recent residential key event change. Charlie’s most recent residential Key Event Change (KEC) occurred when he was admitted to the hospital (HOSP) on April 23, 2011. Similarly, “EMP STAT DATE” indicates that Charlie has been unemployed (UNEMP) since September 30,
2006. As of the date of this report, Charlie is not in school (NIS), is on Payee Status 2, is on conservatorship (Y), and receives $880 per month from SSI. He also has three chronic health conditions: diabetes, obesity, and substance or alcohol abuse. This cell appears in red because he has three or more chronic conditions. On the positive side, he is engaged in some kind of health management behavior for his diabetes (Y), but not for his obesity (N). He does have a primary care physician (Y) whom he last saw on July 10, 2010. The healthy behaviors ("HLTHY BHVRS") column indicates that Charlie is in a smoking cessation program. The psychiatric medications management ("PSYCH MED MGMT") column indicates that he is receiving psychiatric medications twice a week; and the “active substance abuse” column indicates that, as of January 15, 2011, he was judged to be actively using drugs or alcohol (Y).

The percentages at the bottom of the quality-of-life columns reflect the percentage of the line staff member’s time that was spent working with the client on each of the quality-of-life domains. In this case, John Doe spent 20% of his time with Charlie working on his residential status, none on his employment and education statuses, and 30% of his time on his payee status. Knowledge of these percentages allows the line staff person and his supervisor to determine if they should shift the way the line staff is working with the client.

The “service activity,” “service content,” “documentation,” and “goal” sections of the registry are designed to allow the supervisor and the direct service staff to understand precisely what each direct service staff member has been doing with the clients on his or her caseload. The “service activity” section reveals how often and where the Personal Service Coordinator (PSC) and the client are interacting. The “service content” section displays the three most prevalent types of activity that the line staff person performed for the client during the month.

This summary allows the supervisor and line staff person to evaluate whether the kinds of activities that the line staff person is performing are appropriate for the client’s stage in the recovery process.

The “documentation” section of the registry covers administrative aspects of the client’s care, and indicates whether required paperwork is being kept up to date.

The “goal” section simply contains a re-statement of the client’s goal in his or her own words.
## Caseload at a Glance: Monthly PSC Activity Detail
Through April 30, 2011 (Print date 5/10/2011) – PSC: John Doe

<table>
<thead>
<tr>
<th>MEMBER NAME</th>
<th>ADMIT DATE</th>
<th>MORS -6</th>
<th>MORS -5</th>
<th>MORS -4</th>
<th>MORS -3</th>
<th>MORS -2</th>
<th>MORS -1</th>
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<td>CONS STAT DATE</td>
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<td>LOC COM %</td>
<td>LOC PHN %</td>
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<td>Safety net</td>
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<td>Rehabilitation</td>
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<td>Crisis intervention</td>
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<td>Welcoming</td>
<td>Building and maintaining a safety net</td>
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<td></td>
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<td>Building personal growth and responsibility</td>
<td>Community development</td>
<td>Rehabilitation</td>
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<td>Skill building</td>
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<td>Community development</td>
<td>Building personal growth and responsibility</td>
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<td>N</td>
<td>N</td>
<td>OVERDUE 4/30/11!</td>
<td>Y</td>
<td>N</td>
<td>I want to get off of money management.</td>
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<td>N</td>
<td>Y</td>
<td>5/31/11</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>I want to be happy.</td>
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<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>I want to finish school and get a law degree.</td>
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<td>OVERDUE 4/1/11</td>
<td>OVERDUE 3/31/11</td>
<td>Y</td>
<td>5/31/11</td>
<td>Y</td>
<td>N</td>
<td>I want to be a better caregiver.</td>
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<td>Nicolas A.</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>I want to stop drinking.</td>
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<tr>
<td>Roy S.</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>I want to stay clean and sober, someday do volunteer work, and eventually have my own house.</td>
<td></td>
</tr>
<tr>
<td>Julia M.</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>I want to spend time with my children.</td>
<td></td>
</tr>
<tr>
<td>Eva P.</td>
<td>Y</td>
<td>5/31/11</td>
<td>OVERDUE 4/30/11!</td>
<td>Y</td>
<td>Y</td>
<td>I want to get a job in the community and be financially independent.</td>
<td></td>
</tr>
<tr>
<td>Eleanor S.</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>I want to be independent.</td>
<td></td>
</tr>
<tr>
<td>Tom C.</td>
<td>Y</td>
<td>5/31/11</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>I want to finish [writing] my book, I want to slow down, lighten up, and take life less seriously.</td>
<td></td>
</tr>
</tbody>
</table>
Utilizing Data Reporting and Findings – Orange County

Example of Utilizing Data and Reporting Findings

Orange County Adult Mental Health Services

Use of Data and Outcome Measures to Drive Practices

Orange County has made a concerted effort to inform our providers via data monthly. Providers collect data in real time, and at the end of each month they validate and submit their data to the county. Once their data are submitted, a data analyst runs queries to compile areas of information, including demographics, incarcerations, hospitalizations, homeless days, education, and employment.

The data are then transferred to an easy-to-read Microsoft Excel spreadsheet. Graphs (like the sample below) are auto-populated, and all of the information is combined into a progress report. The report is distributed to providers monthly. Graphs are used to communicate a large amount of information in a relatively small area. At the end of the fiscal year, the data are examined as a whole so that providers and county staff members can assess and analyze data from the previous year.
From these assessments, decisions are made that either change an FSP’s course or maintain existing practices. In the past fiscal year, education and employment days were to some extent lower than they could be. In the first five years of MHSA implementation, the focus of FSPs was to reduce incarcerations, hospitalizations, and homeless days, which often overshadowed directing individuals to education or employment opportunities.

Close analysis of program data along a continuum will lead to identification of practices that work and produce positive outcomes, as well as those that precipitate gaps in service. These gaps are areas in which clinical interventions need to be explored and implemented. The ongoing focus on data and outcomes can help program administrators gain insight into the success or failure of the implemented practice.

The use of data has encouraged renewed focus on community integration, employment, and education. Orange County program administrators hope not only to continue these practices but also to improve upon them each year. They realize they must examine what programs have done in the past as well as to anticipate what programs can, and will accomplish in the future.