LPS CLINICAL ASSESSMENT GUIDELINES

for Improved Assessment and Delivery of Clinical Service to Involuntarily Detained Individuals

Module 6, Part II

Tools and Strategies using Data Available in Public Records Relevant to Performance Measurement applicable to LPS Clinical Assessment Guidelines – An Abridged Adaptation of the CIBHS Full Service Partnership (FSP) Performance Measurement Toolkit

Contents

Overview of Performance Measurement Part II

As part of the development of LPS Clinical Assessment Guideline Toolkits, the performance measurement component seeks to articulate a framework for performance measurement in the various service system aspects that influence quality of care during involuntary detentions. The technical issues associated with performance measurement are addressed in evaluation approaches commonly used in public health, education, human services, and other related programs.

The optimal approach is the adoption of a statewide universal framework to resolve technical complexities related to program evaluation for a performance measurement toolkit. The Centers for Disease Control and Prevention (CDC) Framework for Program Evaluation in Public Health ((1999) is a nationally recognized framework for program evaluation. While designed originally for public health professionals, it is widely used across various fields of practice. The framework comprises six steps 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

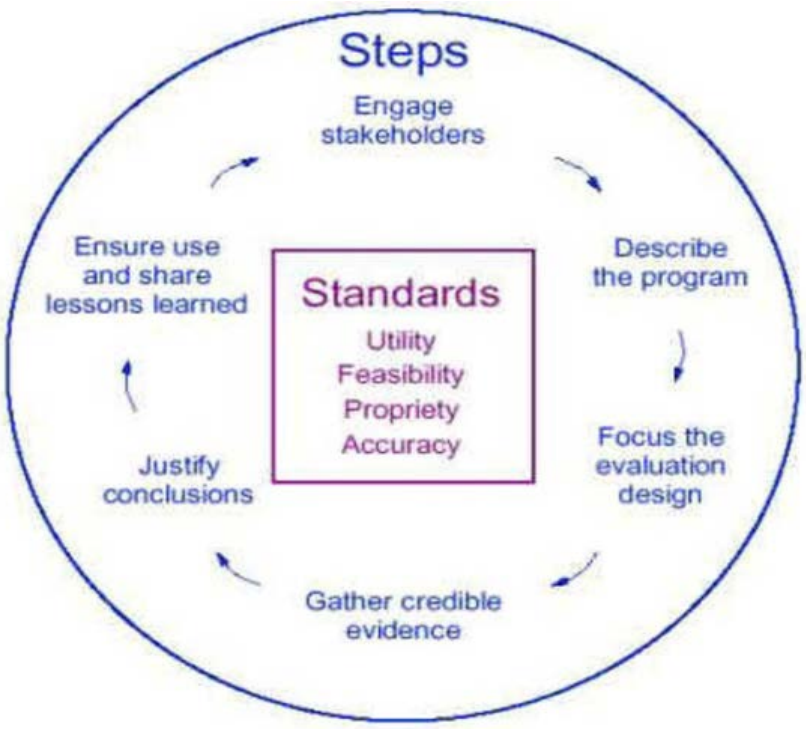
Feasibility: to be realistic, prudent, diplomatic, and frugal

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

Accuracy: to reveal and convey technically accurate information.

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

The six steps within the framework provide a meaningful and practical structure for the LPS Clinical Assessment Guidelines Performance Measurement Manual adapted from the framework, Part II includes six chapters (2-7), each with specific evaluation topics relevant to performance measurement. of this toolkit.



Performance Measurement Part II seeks to articulate a framework for performance measurement in the various aspects of a service system that influence quality of care during involuntary detention. The evaluation technical issues that are associated with performance measurement are addressed in evaluation approaches commonly used in public health, education, human services and other programs.
The framework comprises six steps in evaluation that make up the basic elements of evaluation.

- Utility – to serve the information needs of the 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
- Accuracy – to reveal and convey technically accurate information

The six steps within the framework provide a meaningful and practical structure for the LPS Clinical Assessment Guidelines.

The California Institute for Behavioral Health Solutions (CIBHS) Full Service Partnership (FSP) Performance Measurement Outcome Toolkit provides a thorough and relevant description of an effective research design development process, a way to include stakeholders in a study, and principles of data analysis and interpretation. These performance outcome measures are also appropriate for the CAG guidelines, with some minor modifications. The FSP Performance Measurement outcome toolkit has been adapted specifically for the Clinical Assessment Guidelines Toolkit and is presented as an abridged version in this module. The adaptation aims to assist providers to use data available in public records that are relevant to performance measurement.

The major focus of this section is measurement of practice implementation fidelity the extent to which services are being provided in the manner called for by the LPS Clinical Assessment Guidelines

For example, to what extent are the various recovery model-based guidelines, such as those related to shared decision-making, being used with clients?

Attention is also given to evaluating administrative guideline implementation projects and outcome evaluations that examine how exposure to guideline-based practices affect clients' lives.

For example, an outcome study might examine the extent to which shared decision-making reduces the frequency of re-hospitalizations.

As long as the distinctions between (a) implementation project evaluation, (b) implementation fidelity, and (c) outcomes are kept in mind, the Performance Measurement section provides:

- a thorough and relevant description of an effective research design development process
- strategies to include stakeholders in a study
- principles of data analysis and interpretation.

Terminology

Client: Universal identifier for an individual with lived experience.
Program: Broadly describes the object of evaluation. It is a general term to describe those direct services interventions strategies and systems that implement the LPS Clinical Assessment Guidelines.
Project or implementation project: Describes the administrative efforts such as training, supervision, policy and procedure development and resource allocations designed to disseminate the implementation of these guidelines.

Chapter 1: Evaluating Guideline Implementation within a System of Care

Not all individuals held in involuntary detention have had prior contact with behavioral health outpatient therapeutic, case management, or rehabilitation services. However, for the significant proportion who have had such contact, the individual's experience of emergency or inpatient services and staff's ability to implement many of the CAG Guidelines is greatly affected by such prior outpatient services.

Evaluations of inpatient program performance vis-a-vis the guidelines must be interpreted in the context of the services from which the client has come, as well as those that should be identified in an inpatient's discharge plan. Much of this historical and contextual information is contained in outpatient clinical records.

Implementation Fidelity Studies

Several important questions might be asked about the LPS Clinical Assessment Guidelines.

- What administrative and supervisory efforts have been made to implement the guidelines? (formative evaluation)
- To what extent have the guidelines been implemented?
- To what extent has their implementation led to improvements in the quality of life for involuntarily detained individuals? (summative evaluation)
- To what extent has their implementation led to improvements in the efficient and effective functioning of public behavioral health service systems? (summative evaluation)

Clearly, the third and fourth questions cannot be answered until the second question has been answered. The guidelines can only affect the lives of clients and the functioning of service systems to the extent that they are implemented in practice.

The performance indicators contained in this module are designed for use in implementation fidelity studies. Once it has been determined that a particular program is serving clients and the community with a high degree of fidelity to the guidelines, we can conduct summative evaluations to answer questions such as,

Do the LPS Clinical Assessment Guidelines, when implemented, lead to:

- greater consumer satisfaction?
- improved psychosocial functioning?
- progress on the milestones to recovery scale?
- better engagement in post-discharge community resources?
- fewer hospitalizations?
- less use of seclusion and restraint during hospitalization?

Questions such as these can be answered by comparing consumer satisfaction and psychosocial functioning status:

- pre and post implementation status
- in counties with high degrees of fidelity to the guidelines with comparable counties that have low degrees of fidelity to the guidelines.

Clinical Records as an Evaluation Database

Clinical records are expected to document clinically significant information, especially with regard to the information provided by staff for purposes of informed consent and orientation to a service program, recommendations, interventions, and communications with colleagues and the client's significant others.

Such expectations are established in the codes of ethics for each major behavioral health profession, as well as in the unprofessional conduct sections of state license laws for these professions. For example:

> (American Psychological Association) 6.01 Documentation of Professional and Scientific Work and Maintenance of Records
>
> Psychologists create and to the extent the records are under their control, maintain, disseminate, store, retain and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law.
>
> (California Association of Marriage and Family Therapists) 1.15 Documenting Treatment Decisions
>
> Marriage and family therapists are encouraged to carefully document in their records when significant decisions are made.
>
> 3.3 Clinical Records
>
> Marriage and family therapists create and maintain client records, whether written, taped, computerized, or stored in any other medium, consistent with sound clinical practice.
>
> (National Association of Social Workers) 3.04 Client Records
>
> (a) Social workers should take reasonable steps to ensure that documentation in records is accurate and reflects the services provided.
>
> (b) Social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future.
>
> (American Medical Association) 5 The Principles of Medical Ethics, with Annotations Especially Applicable to Psychiatry

A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to clients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated. (5-2) In the practice of his or her specialty, the psychiatrist consults, associates, collaborates, or integrates his or her work with that of many professionals, including psychologists, psychometricians, social workers, alcoholism counselors, marriage counselors, public health nurses, and the like. . . . (5-3) When the psychiatrist assumes a collaborative or supervisory role with another mental health worker, he or she must expend sufficient time to assure that proper care is given.

(Contract between the County Mental Health Plan and the California DHS) Documentation Standards for Client Records

The clinical documentation will include updated information regarding:

- presenting problems and relevant conditions affecting physical and mental health (e.g. living situation, daily activities, social support)
- client strengths in achieving service plan goals
- special status situations that present a risk to client or others
- mental health history including previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information, past and present use of tobacco, alcohol, caffeine and all other drugs, DSM diagnosis, or ICD diagnosis consistent with the presenting problems, history, mental status examination and/or other assessment data.

The client plan will:

- have specific, observable, and quantifiable goals
- identify the proposed type(s) of intervention
- have interventions consistent with goals
- be consistent with the diagnosis
- document client's participation in and agreement with the plan.

Progress Notes will:

- be related to the client's progress in treatment
- provide timely documentation of relevant aspects of client care

Document:

- client encounters
- clinical decisions
- interventions
- referrals to community resources
- follow-up care.

California Business and Professions Code Sec. 4992.3 (LCSW) and Sec. 4982 (LMFT)

The (licensing) board may deny a license or a registration, or may suspend or revoke the license or registration of a licensee or registrant if he or she has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

(t) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

Most LPS Clinical Assessment Guidelines refer to one or more of these issues. They are the clinically significant aspects of service, which are especially important for those individuals with a potential need for involuntary holds. Therefore, risk management attorneys often say that, for forensic purposes, "If it isn't documented it didn't happen." The same principle applies to the use of clinical records for program evaluation purposes. Therefore, the clinical record provides a viable data source for reviewing implementation of many of the guidelines.

Each individual county behavioral health department should determine which of the LPS Clinical Assessment Guidelines are and are not clinically significant enough to require that information demonstrating compliance with the guideline should be required in a client's clinical record at all points in the system of care.

Client Surveys as an Evaluation Database

Some LPS Clinical Assessment Guidelines refer to the kinds of client experiences that should be achieved (e.g., feel safe, include family members as identified by client, client concerns about things). The client is usually the best source of information about what he or she has experienced, and this information is not necessarily accurately reflected in the clinical record.

Some LPS Clinical Assessment Guidelines refer to the kind of information a client should have. Most of these guidelines do not simply state that information should be presented to the client, but that the client should be *informed*. Whereas clinical records will often state that information was provided to a client, they do not always document whether the client clearly understood (i.e., was informed by) the information.

Client surveys are often the best source of information regarding what the client has experienced and is informed about. Engaging clients in evaluative efforts is consistent with recovery model principles regarding client self-responsibility and engagement in meaningful life roles.

Judgments Regarding Adequacy

Most LPS Clinical Assessment Guidelines are stated so as not lend themselves to simple judgments of whether something has occurred. Instead, judgments usually need to be made about how adequately the guideline was met.

Unless a guideline lends itself to a simple yes/no judgment, criteria, or standards must be developed that either (a) define acceptable compliance with the guideline or (b) define several degrees of compliance, such as: “not at all,” “equivocal,” “adequate,” “very good,” and “expert.”

The following chart provides examples of indicators that can be used to measure implementation fidelity to the LPS Clinical Assessment Guidelines. These are only offered as examples. Actual planning of the performance measurement project should begin with a decision-making process to establish standards such as these. The guidelines were established with input from various kinds of stakeholders including consumers, family members, service delivery staff, and administrators. Therefore, the standard setting process should include participants from these same stakeholder groups. This should lead to capturing the intended meaning of each guideline and serve as a valuable staff development process as well as helping participants to become familiar with what is expected of them.

GUIDELINE	INDICATORS
Stabilization and De-escalation	
1. Both first responders and behavioral health service staff should identify and document: 1.01 (a) the specific factors that led the officer to declare a need for involuntary hold 1.01 (b) input from family members, when possible 1.01 (c) the individual’s disposition, location, and history, if known 1.01 (d) indicators of medical, psychiatric, and physical needs, if known.	1.01 (a) can be measured by a review of documentation. Evaluation should determine: • how specific are the documented factors • how adequate is the rationale for the 5150. Track changes (improvements) over time. Items (b), (c), and (d) contain contingencies. Interviews would be required to determine “if possible” and “if known.”

GUIDELINE	INDICATORS
Stabilization and De-escalation	
2. Engagement 2.01 Exercise clear and effective communication skills. 2.02 Validate the individual's perspective of the situation. 2.03 Create nonjudgmental, supportive environments. 2.04 Create environments that feel safe (e.g., evaluate the need for handcuffs, police car, ambulance). 2.05 Inquire about the individual's comfort (e.g., dry, warm clothing, food, water) prior to making assessment inquiries. 2.06 Address client concerns about personal effects (e.g., cars, bikes, pets, personal belongings, home). 2.07 Develop and implement an action plan to secure personal effects. 2.08 Include family members and significant others as identified by the client 2.09Focus the engagement process on discharge. 2.10 Practice a recovery orientation.	2.01 The kinds of communication skills and practices referenced in this set of guidelines are commonly evaluated in internship and residency programs where a substantial portion of faculty and supervisor time is allocated for the evaluation function. (Manring et al. 2003). 2.04–2.08 Items related to client's experience could be assessed using a client survey, especially regarding: • environments that feel safe • inquiries about comfort • client's concerns about personal effects • inclusion of significant others per client's request. Survey a sample of clients to determine which family members they identified to be included. Compare this to (a) documented contacts with family members and (b) surveys of those family members regarding their report of contact from staff. Track changes (improvements) over time. Additional information about client surveys and other options relevant to this set of guidelines are available at: http://drbeitman.com/Papers/Evaluating%20Competence%20in%20Psychotherapy.pdf on the Web.

GUIDELINE	INDICATORS
Stabilization and De-escalation	
3. Initial Clinical Assessment Initial Clinical Assessment Process by Behavioral Health Staff 3.01 Use a team or collaborative process whereby the mental health clinician references the information from the first responder, including information about prior law enforcement contact. 3.02 Access behavioral health records as much as possible. 3.03 Draw out the individual's own experience of the situation (through "inquiry not accusation"). 3.04 Conduct a systematic review of interventions that have previously benefitted the detained individual. 3.05 Inform the first responder regarding the disposition of the involuntary hold and status of the individual following the assessment.	Review sample of charts for presence and number of: 3.01 references to information from first responders and information about prior law enforcement contact 3.03 descriptions of client's own experience of the situation 3.04 references to previous interventions that have benefitted the client 3.05 references to follow-up communication with the first responder. Track changes (improvements) over time. 3.02 This item contains a contingency ("if possible"). Interviews would be required to determine what was possible.

GUIDELINE	INDICATORS
Stabilization and De-escalation	
3. Initial Clinical Assessment Initial Clinical Assessment Content 3.06 Assess the medical necessity for involuntary hold. 3.07 Include information about history of care. 3.08 Identify alternatives to the hold, such as community and family supports and reasons for using or not using these alternatives. 3.09 Identify the individual's needs regarding securing personal property, pets, cars, other family members, dependent children, safety, and medical/ physical needs. 3.10 Identify strengths (e.g., problem-solving abilities, capacity to engage others, interests and motivations, awareness of strengths and limitations, symptom management abilities). 3.11 Include information about involvement with support systems (e.g., family, friends, agencies). 3.12 Address issues relevant to the client's ethnicity; social class; religious, gender, and sexual orientation; and generational or other cultural considerations. Be linguistically appropriate. 3.13 Address any ongoing assessment content that is logistically feasible in view of time constraints and the client's ability to communicate such information.	Review sample of charts for: 3.07 history of care (per a predetermined standard) 3.09 individual's needs regarding personal property and the like (per a predetermined standard) 3.10 strengths (per a predetermined standard, including those specified in the guidelines) 3.11 information about support systems (per a predetermined standard) 3.12 diversity issues as relevant to each individual client (per a predetermined standard). Survey clients and significant others, if involved, regarding what they were told regarding: 3.08 alternatives to the hold. Track changes (improvements) over time.
4.0 Admission: There were no guidelines for this segment. It was agreed upon by the expert panel and regional stakeholders that the admission process is generally standard across counties.	

GUIDELINE	INDICATORS
Stabilization and De-escalation	
5. Ongoing Assessment Ongoing Assessment Process 5.01 Use a team approach or collaborative process. 5.01 (a) Use an assessment team make of friends, family members, and so on as requested by the client. Inclusion of family members can provide significant information about individual history, daily routines, and so on that could influence the assessment and intervention plan. 5.01 (b) The client should be made aware of the option of including family members and significant others in the assessment process and the potential benefits of doing so. 5.01 (c) The client's decisions about engaging others should be respected. 5.01 (d) Access behavioral health records, including a review of the client's own crisis-related perspectives and preferences as expressed in documented pre-detainment assessments. 5.01 (e) Draw out the individual's own experience of the situation (through "inquiry not accusation"). 5.01 (f) Use motivational interviewing principles, as relevant. 5.01 (g) Facilitate the client's communication with individuals and resources with whom the client chooses to communicate to obtain information about his or her history, status, and post-discharge options. 5.01 (h) Facilitate the client's communication with those individuals and resources whom the client chooses to invite as participants in the discharge-planning process.	5.01 (a) Review a sample of charts to determine what proportion had family members and friends contacted for assessment information and the telephone number or email of such individuals who were contacted. 5.01 (b) Survey a sample of clients to find out what proportion were informed of options of including family members and significant others in the assessment process and the potential benefits of doing so. 5.01 (c), (g) and (h) These items require a comparison of information from client surveys (i.e. what decision was made regarding inclusion of others) and chart documentation, specifically in what proportion of cases were: (c) the documented staff actions consistent with the client's decision (g) if applicable, actions taken to facilitate client communication with client's chosen resources (h) if applicable, actions taken to facilitate client communication with those chosen to participate in the discharge planning process. Track changes (improvements) over time.

GUIDELINE	INDICATORS
Stabilization and De-escalation	
5. Ongoing Assessment Ongoing Assessment Content 5.02 The ongoing assessment should inform Discharge Planning decisions and occurs simultaneously with the discharge planning process (not yet a concluded discharge plan). 5.03 To inform Discharge Planning of the ongoing assessment, include content that informs: 5.03 (a).decisions regarding restoration of role functioning and/or introduction to new roles 5.03 (b) the individual's stage of change so that discharge plan goals and objectives can be linked to the individual's stage of change 5.03 (c) a determination of the kinds of goals and objectives that would be realistic, achievable, meaningful to the individual, and either initiated by or acceptable to the individual. 5.04 Include information about history of care that may be available from other sources. 5.05 Identify the individual's needs in regard to securing personal property, pets, cars, other family members , including dependent children, safety, and medical/ physical needs.	5.02 Survey discharge planning staff regarding what information was communicated to them by staff conducting ongoing assessments. What information from that was helpful in discharge planning? What information would have been helpful was not available from the ongoing assessment? 5.03 (a), (b) and (c) Review a sample of clinical records. What proportion contain information regarding clients': • pre-admission role functioning • stage of change • desired goals • other issues reported by discharge planning staff as relevant to the issues addressed by these three guidelines. 5.05 Review a sample of charts for the referenced information. Track changes (improvements) over time.

GUIDELINE	INDICATORS
Stabilization and De-escalation	
5. Ongoing Assessment Ongoing Assessment Content (cont.) 5.06 Identify strengths (e.g., problem solving capacities, ability to engage others, interests and motivations, awareness of strengths and limitations, symptom management abilities). 5.07 Include information about client's involvement with support systems (e.g., family, friends, agencies). 5.08 Address issues relevant to the client's ethnicity; social class; religious, gender, and sexual orientation; generational or other cultural considerations. Be linguistically appropriate. 5.09 Evaluate the individual's function (e.g., employment, raising children, participation in training or education, neighborhood participation). 5.10 Identify individuals and resources with whom the individual chooses to communicate during the detainment. 5.11 Identify those individuals and resources whom the individual chooses to participate in the discharge planning process.	5.06, 5.07 and 5.09 For clients with pre-admission outpatient contacts: (a) Review outpatient chart to identify the presence of each strength or issue listed in these guidelines. (b) Review the inpatient chart to see which of those strengths or issues were referenced by the inpatient staff. 5.06, 5.07 and 5.09 For clients without pre-admission outpatient contacts: (a) Survey a sample of clients to identify the presence of each strength or issue listed in these guidelines. (b) Review the inpatient chart to see which of those strengths or issues were referenced by the inpatient staff. 5.10 and 5.11 Compare responses to a survey of clients with inpatient documentation. In what proportion of cases were these congruent? Track changes (improvements) over time.

GUIDELINE	INDICATORS
Stabilization and De-escalation	
6. Formulation/Narrative 6.01 The formulation should clearly convey: 6.01 (a) the documented diagnosis(es) is (are) valid 6.01 (b) which problems are primarily due to the symptoms of the diagnosed mental disorder 6.01 (c) which problems are primarily due to factors other than symptoms of the diagnosed mental disorder 6.01 (d) which strengths are relevant to solving each major problem 6.01 (e) which resources are available for solving each major problem.	6.01 (a) Review a sample of charts to answer: Were DSM criteria met for the documented diagnosis(es)? Were diagnoses evident from symptom descriptions but not documented? 601 (b) Review a sample of charts to answer: What proportion of functional problems were linked to: • specific symptoms as a cause or trigger (not only to a diagnosis)? • a cause or trigger other than symptoms of a mental disorder? Were distinctions made between causes and triggers of functional problems? 6.01 (d) and (e) Review a sample of charts to answer. What were the three most impactful problems identified in the chart? What proportion of those major problems were linked to: • relevant strengths? • resources? Track changes (improvements) over time.

GUIDELINE	INDICATORS
Stabilization and De-escalation	
7. Treatment (Decision-Making and Intervention) 7.01 The assessment of treatment includes: 7.01 (a) recommendations made to the individual during the hold 7.01 (b) individual's response to recommendations 7.01 (d) therapeutic interventions provided to the individual during the hold 7.01 (d) individual's response to therapeutic interventions provided 7.01 (e) contacts with significant others during the hold 7.01 (f) individual's response to contacts with significant others 7.01 (g) an evaluation of the individual's potential and willingness to engage in outpatient care and supports 7.01 (h) staff communication and collaboration with potential outpatient follow-up service providers 7.01 (I) client communication with potential outpatient follow-up service provider 7.01 (j) access to centralized information within a system of care, fully implementing the "portability" purpose of HIPAA while remaining within the confidentiality and security provisions of HIPAA.	7.01 Identify a set of key recommendations and interventions needed by all on involuntary holds. Review charts to determine, in each case, what proportion of: • these recommendations were made? • charts documented client response to these recommendations? • the key interventions were made? • charts documented client response to these interventions? • charts documented an evaluation of the individual's potential and willingness to engage in outpatient care and supports? • charts documented: – staff collaboration with outpatient follow up providers, and number of contacts per case? – client communication with outpatient follow up providers, and number of contacts per case? Track changes (improvements) over time.

GUIDELINE	INDICATORS
Stabilization and De-escalation	
8. Discharge Planning 8.01 Discharge decisions should be informed by a validated instrument whenever possible. 8.02 Discharge decisions should be based on a documented, systematic review of interventions that have previously benefitted the detained individual. 8.03 Exercise clear and effective communication skills. 8.04 Validate the individual's perspective of the situation. 8.05 Include family members and significant others as identified by the client. 8.06 Focus the discharge process on post-discharge follow-through. 8.07 Express a recovery orientation, therefore discharge plans must: 8.07 (a) be person centered 8.07 (b) reflect client's self-direction and build self-responsibility 8.07 (c) empower the client with information and linkage to supportive resources 8.07 (d) be strengths based 8.07 (e) be respectful.	8.01 Which validated instruments have been adopted by the service system? Review charts to determine the proportion of charts in which these instruments were used. 8.02 Identify standards for what constitutes a "systematic review" of previously beneficial interventions. Review charts to determine the proportion of charts in which these standards were met. 8.03 See Item 2.01 above. 8.04, 8.07 (c), (e), (f), and (g) Items related to client's experience could be assessed using a client survey, especially regarding: • information received about supportive resources • whether you feel respected • your cultural identity and whether your discharge plan addresses each of these • whether you are more hopeful now than you were before you participated in developing this discharge plan. 8.05 Survey a sample of clients to find out which family members they identified to be included. Compare this to (a) documented contacts with family members and (b) surveys of those family members regarding their report of discharge planning contact from staff.

GUIDELINE	INDICATORS
Stabilization and De-escalation	
Discharge Planning (cont.) 8.07 (f) be culturally relevant (regarding ethnicity, religion, social class, gender and sexual orientation, and other cultures that are meaningful to the client) 8.07 (g) be hopeful and stimulate hope 8.07 (h) identify relevant community-based services and natural support networks 8.07 (i) not be limited to professional interventions 8.07 (j) focus on quality-of-life goals and meaningful life roles 8.07 (k) express goals/objectives that are sufficiently clear and specific to enable valid and reliable outcome evaluation.	8.07 (k) Ask a sample of clients, "How will you know when each of these goals/objectives has been achieved?" Ask the same question of (a) a family member, (b) an outpatient staff member, (c) the inpatient staff. Are their expectations congruent? Track changes (improvements) over time.
9. Care Coordination 9.01 Confirm that the planned follow-up resources are in place and ready to engage with the individual. 9.02 Confirm that the individual remains committed to the decisions about the use of chosen follow-up resources and remains willing to follow through. 9.03 Confirm that the clients' basic needs (e.g., housing, meals, adequate clothing, access to medications) can and will be met if the individual and designated resources follow through on their commitments.	9.01 Review charts to determine: • how many planned follow-up resources were listed • how many resources were confirmed for availability. 9.02 Review charts to determine reference to client's confirmed commitment. 9.03 Identify standards specifying which basic needs must be addressed. Require that each be addressed with a documented confirmation. Review charts for confirmed reference to each basic need. Track changes (improvements) over time.

GUIDELINE	INDICATORS
Stabilization and De-escalation	
10. Discharge 10.01 Provide the individual with an opportunity to say good-bye to staff and peers as best as possible. 10.02 Assess, with the individual, progress accomplished during the hold. 10.03 Convey a realistic sense of the individual's positive course of resolution that can be projected into the future; assess the individual's awareness of these positive developments. 10.04 Assess, consulting with the individual, how the present experience of stabilizing and resolving the crisis state may be helpful in coping with future crises.	10.01 Survey a sample of clients to determine, to their satisfaction, whether they had an opportunity to say good-bye to peers. 10.03 Survey a sample of clients to determine their awareness of positive developments resolved during the inpatient stay. Confirm whether these developments were reviewed with them by staff. 10.04 Survey a sample of clients to determine their awareness of how the present experience of stabilizing and resolving the crisis state may be helpful in coping with future crises. Confirm whether these issues were reviewed with them by staff. Track changes (improvements) over time.
11. Supports for Wellness and Recovery 11.01 A post-crisis management team should be provided for this phase of support. 11.01 (a) The post-crisis management team should function as a wraparound-type of warm handoff to community services and linkage for family supports. 11.01 (b) The post-crisis management team should follow up with individuals after discharge to ensure that they then connect with outpatient services. 11.01 (c) Engage peer support organizations to participate on the team because offering aftercare and resource educators, liaisons, and aftercare case managers was recommended as a best practice. 11.01 (d) The post-crisis management team should use best practices such as Emotional CPR (National Empowerment Center). 11.02 Whether construction of a post-crisis management team as a stand-alone resource is possible, increased care coordination among disparate agencies ultimately serving the same individuals should serve this function in a de facto manner. 11.03 Engage the supportive efforts of peer navigators.	11 For counties with a post-crisis management team, survey a sample of clients to for answers to the following questions. • Did the team contact you since you were discharged from inpatient services? • Did the team ask you about your connection with outpatient services? • What is a peer support organization? (If the client does not know the answer, give a definition and examples.) • Did a peer support person from the team contact you regarding how well you are doing in the community? 11.02 What proportion of cases have documented contact information for service agencies relevant to the client's needs? What was the number of such contacts documented per case? What proportion of these contacts were newly documented following inpatient discharge? Track changes (improvements) over time.

GUIDELINE	INDICATORS
Stabilization and De-escalation	
12. Pre-detainment Assessment Pre-detainment Assessment Process Clearly, a mentally ill individual will be much better able to receive, consider, communicate, deliberate about options, and arrive at informed preferences over the course of many months of outpatient services while in stable circumstances, in contrast to the hectic turmoil of a 5150 crisis. Of course, the individual being involuntarily held still has the right to make and change decisions at that time, but effective planning in anticipation of a possible 5150 hold provides the client in crisis with the benefit of reflecting on his or her own previously expressed decisions. 12.01 Whenever this information can be gathered during pre-detainment service contacts within a service system, those issues involving decisions (e.g., identifying client preferences) will be made using a process of shared decision-making in which: 12.01 (a) the service provider and client communicate using the best available evidence 12.01 (b) clients are supported to deliberate about the possible attributes and consequences of options 12.01 (c) informed preferences are determined based on a choice of the best action that respects client autonomy, to the extent this is desired, ethical, and legal. 12.02 Clients should be made aware of the option of including family members and significant others in the assessment process and the potential benefits of doing so. 12.02 (a) Clients who have considered and made decisions about including family and significant others during the outpatient service assessment process will be best able to formulate such decisions during the course of their detainment-based assessments.	12.01 What proportion of a sample of outpatient charts document client's choices or preferences regarding: • whether to include significant others in their care? • which significant others to include? • preferred medications? • medications to be avoided? • which community resources are valued by client? • what arrangements they would want if an involuntary hold was ever needed? 12.02 Review a sample of charts for documentation: • that this information was provided • of the client's response to this information Track changes (improvements) over time.

GUIDELINE	INDICATORS
Stabilization and De-escalation	
12. Pre-detainment Assessment Pre-detainment Assessment Process (cont.) 12.03 Conduct the pre-detainment assessment to strengthen the client's decision-making capacity. 12.04 Use a shared decision-making process. A systematic approach to decision-making is a skill. Most people need to practice systematic approaches to decision-making, just as we need to practice any skill. The client with repeated opportunities to do so during a course of outpatient services will be best empowered to do so when presented with a shared decision-making approach during an involuntary hold. To support the development of decision-making skills, staff should implement the following guidelines during pre-detainment assessments. 12.04 (a) If the client brings up a cluster of issues, see if it helps to partialize and prioritize these. 12.04 (b) The client's subjective experience and response to each issue should be identified and clarified. 12.04 (c) Weigh alternative options by trying them out hypothetically in discussion. For example,"What do you like best about this? What do you like least about that?" 12.04 (d) Ask the client to choose preferences, but don't limit choices to only one primary preference unless the client chooses to do so. 12.04 (e) Help the client identify the steps taken in identifying preferences.	12.04 Select a sample of outpatient charts that have been open for over 1 year. Determine in what proportion of the charts was there documented evidence of partializing and prioritizing when the client raised a cluster of issues. Identify up to three issues that required a client's decision. In what proportion of the charts was there documented evidence of: • client's experience of the issues? • client's engagement in weighing alternative options? • client's choice or preference? • the intervention of helping the client identify steps that were taken in identifying preferences? Track changes (improvements) over time.

GUIDELINE	INDICATORS
Stabilization and De-escalation	
12. Pre-Detainment Assessment Pre-Detainment Assessment Process (cont.) 12.05 Make pre-detainment assessment findings accessible during detainment. Whenever information can be gathered during pre-detainment service contacts within a service system, the information should: 12.05 (a) be documented in a record accessible to psychiatric emergency and inpatient services within the same service system 12.05 (b) be accessible to psychiatric emergency and inpatient services within the same service system 12.05 (c) be accessed by psychiatric emergency and inpatient services within the same service system 12.05 (d) be made available to collateral service providers in accordance with the portability provisions of HIPAA and the coordination of care provisions of the Welfare and Institutions Code section 5328 12.05 (e) be accessible to the client by using language the client can understand.	12.05 (c) In what proportion of inpatient charts is there reference to information obtained from: • the outpatient record? • communications with outpatient staff? 12.05 (e) Select a sample of clients with outpatient histories who have been involuntarily held, subject to client's consent to participate. Determine whether access to the clinical record is covered by the HIPAA access to records standards. Present each client with his or her outpatient clinical record. Interview clients to determine their understanding of: • a sample from their assessment findings • each goal/objective from their treatment plan • randomly selected progress notes. Track changes (improvements) over time.

GUIDELINE	INDICATORS
Stabilization and De-escalation	
12. Pre-detainment Assessment Pre-detainment Assessment Content 12.06 Identify the individual's preferences re: 12.06 (a) language for communicating about strengths, symptoms, problems, and service preferences 12.06 (b) family members from whom the client does and does not want to receive support 12.06 (c) friends, peers, staff, agencies, and others from whom the client does and does not want to receive support 12.06 (d) clinical intervention strategies, intervention techniques, medications, and style of relationship with behavioral health service providers.	12.06 Select a sample of clients with outpatient histories who have been involuntarily held within the past 6 months. Interview clients to determine, at the time of having received services: • their preferred language for communicating about major clinical issues • the family members from whom the client did and did not want to receive support at the time of having received services • the significant others and agencies from whom the client did and did not want to receive support at the time of having received services • client's preferences regarding: – clinical interventions – medications – style of relationship with service providers. Review these clients' outpatient records to determine actual: • language used in provided service • family members, significant others, and agencies included in services • which of these were provided: interventions, medications, style of relationship with service providers. Compare documented information with client's reported information. Track changes (improvements) over time.

GUIDELINE	INDICATORS
Stabilization and De-escalation	
12.07. Identify the individual's conception of: 12.07 (a) his or her problems 12.07 (b) possible solutions to problems 12.07 (c) barriers to achieving solutions 12.07 (d) his or her strengths 12.07 (e) the causes of his or her problems 12.07 (f) how significant others view his or her problems 12.07 (g) the types of resources that he or she sees as supportive 12.07 (h) the types of entities that he or she sees as stressful 12.07 (I) the communities with which he or she identifies 12.07 (j) the communities in which he or she prefers to participate 12.07 (k) aspects of life that support solutions to his or her problems 12.07 (l) aspects of life that exacerbate his or her problems 12.07 (m) treatments, advice, help or healing efforts that have been sought out in the past 12.07 (n) the value of treatments, advice, help, and healing efforts that have been sought out in the past 12.07 (o) what he or she has done in the past to deal with the problem that was effective 12.07 (p) what he or she has done in the past to deal with the problem that was ineffective or made the problem worse.	12.07 Select a sample of clients with outpatient histories who have been involuntarily held within the past 6 months. Interview clients to determine their perception of each item listed at the time of having received services. Review these clients' outpatient records to determine what was documented regarding the client's perception of each item listed. Compare documented information with client's reported information. Track changes (improvements) over time.

Engage Stakeholders

The purpose of this chapter is to understand the relevance of the evaluation audience and the extent of the audience's participation in the evaluation process and to include the perspectives of partners to address important elements of a program's objectives, operations, and outcomes.

Engaging stakeholders is a critical component of program evaluation, and it is essential to a successful evaluation.

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.

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:
(a) those involved in program operations (e.g., administrators, managers, staff members, agency partners)
(b) those served or affected by the programs (e.g., clients, family members, advocacy groups, professional associations, skeptics)
(c) 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).

Implementation Strategies

- Identify the potential stakeholders:
  - Clients, primary caregivers, and family members
  - Providers, including administrators, line supervisors, and line staff
  - Allied service delivery systems (e.g., housing services, vocational services, community-based recreation and socialization services, physical healthcare services, law enforcement, legal aid services)
  - Client advocacy groups
  - Unserved and underserved groups
  - Professional associations
  - Boards of supervisors and behavioral 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 (e.g., administrators, managers, staff, agency partners)
  - Stakeholders served or affected by the programs (e.g., clients, family members)
  - Primary users of evaluation findings to alter a program's course (e.g., administrators, managers, supervisors, line staff, providers, funders)

- Define stakeholders' roles because 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, including a matrix developed 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.
- Focus on "early adopters" to work faster toward change. Stakeholder meetings typically encompass three groups of people to promote a large shift in thinking or change. 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 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 LPS Clinical Assessment Guidelines Evaluation

Stakeholder (Individuals and Groups)	Stakeholder Group	Role in Local Evaluation
County administrators and managers directly overseeing involuntary detention services	Primary user and people involved in program operations	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
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
Stakeholder (Individuals and Groups)	Stakeholder Group	Role in Local Evaluation
Community providers (administrators, managers, line supervisors, and staff)	Primary users 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 submit data to the county; to use findings for clinical and programmatic improvement; to be an evaluation participant

Clients and family members (also identify clients from unserved or underserved communities to define specific roles)	Served and affected by the program	As an evaluation participant and/or advisor, to offer reactions and suggestions about process and outcomes measures; to offer comments about implementation of the guidelines (including degree of fidelity to the guidelines); to comment about measurement and data collection; to discuss the usefulness of data in their lives; to be potential advocates for change
State HCSA (Hospital Consultants and Specialists Association.)	Primary user	To provide aggregate data submitted to the state by counties
Board of supervisors	Primary user	To reinforce evaluation goals and objectives; to use evaluation findings for sustainability and funding decisions

Engaging and Retaining Stakeholders in Evaluation

Stakeholder engagement can be a highly involved activity. Patience, time, and perseverance are some of the key ingredients to initiate movement on stakeholder participation engaging and retaining stakeholders in evaluation lends credibility to evaluation findings. Stakeholders also function as advocates.

Implementation Strategies

- Use a participatory evaluation approach that facilitates a partnership between evaluators and stakeholders in planning and implementing the evaluation.
- Engage stakeholders in the evaluation process early and often to maximize the time to involve a broad set of stakeholders.
- 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 be coordinated with other statewide efforts.
- Reach out to a broad spectrum of stakeholders, such as clients detained at emergency services without an inpatient admission, those for whom involuntary detention is their first contact with the service system as well as those with long histories in the service system, those who sought voluntary admission but were involuntarily detained, those who do and those who do not abuse substances, detained children, adolescents and transition-age youth

(TAY), and engage them in quality improvement activities that may influence their own outcomes.

- Consider key elements of successful family member engagement such as 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 and the evaluation process.
- Use skilled facilitators to prepare for and conduct evaluation meetings. Allow facilitators to prepare stakeholders in advance. Preparation will vary for different stakeholder groups.
- Be clear in explaining to stakeholders the purpose and goals of stakeholder participation.
- Create incentives—both monetary and non-monetary—as a strategy for involving clients, their caregivers, and family members.
- Leverage existing resources to involve stakeholders in the evaluation process. Numerous programs throughout the state (e.g., MHSA planning process, MH Planning Council) demonstrate ways in which to engage stakeholders in decision-making processes.
- Use online surveys (e.g., Survey Monkey, Qualtrics) to solicit feedback on evaluation progress and technical assistance needs, and email updates about evaluation progress to stakeholders.

Culturally Responsive and Inclusive Stakeholder Process

Successful engagement of diverse stakeholders including ethnic and cultural representation from neighbor communities enhances the quality of cultural and linguistically appropriate programs and services. Culturally responsive and inclusive stakeholder evaluators foster space for open sharing, participation and power sharing, among all individuals who have an investment in the evaluation process and findings.

Implementation Strategies

- Invite stakeholders who understand the cultural aspects of a program or system of care.
- Explain the evaluation process clearly.
- Value and respect the contributions of those who represent community members, and organizations. As community leaders and representatives, their knowledge and expertise is valuable to the evaluation process.
- Find champions and gatekeepers to communicate with ethnic and cultural communities to

help identify needs of individuals, families and communities.

- Use power brokers (i.e., important individuals representing constituent groups such as clients and service providers) to help frame evaluation around service planning.
- Train staff to explain research procedures and rationale for research clearly to clients their significant others - including family members, faith leaders, and friends.
- Develop evaluation materials in languages other than English for as appropriate for service communities.
- Use an asset-based or strengths-based approach. Use Cultural Formulation Interview located in the DSM 5 as a guide to formulate cultural engagement questions related to evaluation.
- Create a balance and information sharing and action orientation during the meeting. Allow sufficient time for participants to mingle and get acquainted.
- It's always a good idea to provide hospitality in the form of refreshments and light food during meetings.

Systematize the involvement of diverse stakeholders, especially those from unserved or underserved communities. Be mindful not to tokenize the process. Integrate stakeholder involvement into the continuous quality improvement process through focus groups and regular face-to-face interviews. Further, involve underrepresented stakeholders in governance to properly vet expectations of performance measurements and standards.

Each of the tools listed below has specific resources that you can locate in the general resource section. This guide enables you to focus on the pertinent resources linked directly to each tool.

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

Resources

Articles

- Centers for Disease Control and Prevention. "Framework for program evaluation in public health." *MMWR, 48*(RR-11). 1–40; 1999. Available: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm
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Books

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- Wolff, T. *The Power of Collaborative Solutions.* San Francisco, CA: Jossey-Bass; 2010.

Guidebook

- Baker, A. M., and B. Bruner. *Participatory Evaluation Essentials: An Updated Guide for Nonprofit Organizations and Their Evaluation Partners.* Cambridge, MA: The Bruner Foundation; 2010. Available: http://www.evaluationservices.co/uploads/Evaluation.Essentials.2010.pdf

Manuals

- Aubel, J. *Participatory Program Evaluation Manual: Involving Program Stakeholders in the Evaluation Process* (2nd ed.). Baltimore, MD: Catholic Relief Services; 1999. Available: http://www.idrc.ca/uploads/user-S/10504133390Participatory_Program_Evaluation_Manual.pdf
- CDC Evaluation Framework: U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. Office of the Director,
- Office of Strategy and Innovation. *Introduction to Program Evaluation for Public Health Programs: A Self-Study Guide*. Atlanta, GA: Centers for Disease Control and Prevention; 2005. Available: http://www. iphi.nonprofitoffice.com/vertical/Sites/{00CFF503-04BE-4895-B1A4- FF765B2CE512}/uploads/{1D229D07-1D61-45C6-91BA-4CD61BC76856}. PDF

Periodical

- Harvard Family Research Project. *Evaluation Exchange* (A Periodical on Emerging Strategies in Evaluation). Special Issue on Participatory Evaluation; 2005.

Policy Brief

- The National Center for Cultural Competence at Georgetown University Center for Child and Human Development. *Policy Brief on Culturally Competent Strategies for Engaging Diverse Communities.* Available: http://nccc.georgetown.edu/documents/ncccpolicy4.pdf

Reports

- Conklin, A., Z. S. Morris, and E. Nolte. *Involving the Public in Healthcare Policy: An Update of the Research Evidence and Proposed Evaluation Framework*. United Kingdom: RAND Europe (RAND Corporation); 2010. Available: http://www.rand.org/pubs/technical_reports/TR850.html
- Joe, J. R., J. Hassin, X. King, R. S. Young, D. Lopez, D. Washington, and E. Jefferson. *Final Report: Participatory Evaluation of the Lummi Nation's Community Mobilization against Drugs Initiative/Bureau of Justice Assistances Indian Alcohol and Substance Abuse Demonstration Project*. Tucson, AZ: Native American Research and Training Center, University of Arizona; 2008. Available: http://www.ncjrs.gov/pdffiles1/nij/grants/222741. pdf
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Workbook

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Chapter 3: Describe the Program

The next 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's 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 or rationale for such a program, expected effects, activities, resources, stages of development, context, and a logic model.

Developing a Statement of "Need" for Use of LPS Clinical Assessment Guidelines

The process of developing a statement of need for use of LPWS Clinical Assessment Guidelines should include defining the nature and magnitude of the problem, or opportunity for solution that the guidelines address-

- What populations are 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 problems that led to guideline development
- Describing the target population(s) that is (are) affected and 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
- Avoiding unsupported claims or assumptions
- Describe the situation in terms that are both factual and of human interest
- Determine whether the need is changing and in what way the need is changing.

Use culturally appropriate language in a statement of need. For example, terms and concepts such as “recovery,” “wellness,” “self-determination,” “self-responsibility,” and “resilience” are appropriate and meaningful, whereas some child and youth terms such as “attachment,” “developmental assets,” and "developmental progress as individually appropriate" may be less useful in this context.

Use strengths-based language to describe the need and rationale, especially regarding populations that are historically characterized with deficit language such as people of color, LGBT, offenders and the homeless.

Address disparities when working with ethnic populations. For example, describe disparities in access to a full range of behavioral health services and illustrate the impact of the disparities through comparative data charts indicating retention rates, client satisfaction and outcome data.

Defining the Expected Effects of the LPS Clinical Assessment Guidelines

Purpose

To articulate the effects or changes expected from robust use of the LPS Clinical Assessment Guidelines.

Definition

Defining the *expected effects* of the LPS Clinical Assessment Guidelines involves describing the expected changes the guidelines aim to achieve. Because the effects of most guidelines 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 guideline implementation. 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. Involuntary detentions conducted with a high fidelity to the guidelines are an intermediate outcome.

Long-term outcomes are achieved in part by short-term and intermediate outcomes. Typically, long-term outcomes indicate a change in client recovery status and community conditions. Long-term outcomes reflect a larger social consequence of having implemented the guidelines.

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. Goals and objectives of the LPS clinical Assessment Guidelines focus on guideline implementation. Goals and objectives of guideline implementation focus on how clients' lives are affected by having been treated in such a life-enhancing, recovery-oriented manner.
- Anticipate potential unintended positive and negative effects of the program.
- Define expected effects in terms of short-term, intermediate, and long-term outcomes.
- Use existing resources, such as the various LPS Clinical Assessment Guidelines Toolkits and reports of involuntary detentions and measures of any inpatient/outpatient program interface to define expected effects of the LPS Clinical Assessment Guidelines.
- Identify outcomes that might beneficially include allied service delivery programs and systems. For example, broaden involuntary detention outcomes to include outcomes related to greater consumer and community satisfaction with the service system better engagement in post-discharge community resources, or an increase in memoranda of understanding with allied service organizations.
- Define relevant outcomes for racially, ethnically, and culturally diverse clients in emergency and inpatient programs that are culturally targeted. Engage stakeholders in the definition and measurement of these outcomes.
- Differentiate *outcomes* from *outputs*. Outcomes are the results of outputs. Outputs are program processes such as training programs, policy and procedure changes, and changes in program design. These outputs lead to clients' receiving the right kinds of services for their condition, which increases the likelihood of achieving desired results from treatment.
- Differentiate *outcomes* from *outputs*. Outcomes are the results of outputs. Outputs are program processes such as training programs, policy and procedure changes, and changes in program design. These outputs lead to clients' receiving the right kinds of services for their condition, which increases desired out comes for treatment.

Possible Project Outputs

- Review of Guideline relevant ethical standards and clinical practice principles
- Orientation to the Guidelines
- Determine staff level of knowledge and skill regarding Shared Decision-making, Motivational

Interviewing, Verbal De-escalation, Trauma Informed Care, Advance Directives, Wellness Recovery Action Planning and other competencies needed for Guideline implementation, and new assessment tools for predicting violence and other clinical risks:

- Training in these competencies for staff who need it
- Evaluative studies of implementation project progress

Outcome

- High fidelity implementation of the LPS Clinical Assessment Guidelines

Outcomes for People Held in Involuntary Detention

- Securing housing
- Improved access to and engagement with physical healthcare
- Improved social support networks
- Reduced harm from substance abuse
- Increased use of clients' own chosen psychotropic medication
- 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
- Reduction in incarceration rates
- Elevated employment and education rates
- Improved mortality and morbidity rates

Defining Activities in Programs Following the LPS Clinical Assessment Guidelines

The purpose of this section is to identify core program activities logically linked to the expected effects of the guidelines. Defining the *activities in programs* following the LPS Clinical Assessment Guidelines 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 one another?
- Are related programs or partners responsible for any of the program's 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 addressed by key LPS Clinical Assessment Guidelines. For example:

2.01 Exercise clear and effective communication skills.
2.02 Validate the individual's perspective of the situation.
2.06 Address client's concerns about personal effects (e.g., cars, bikes, pets, personal belongings, home).
2.07 Develop and implement an action plan to secure personal effects.
2.08 Include family members and significant others as identified by the client (self-direction); focus the engagement process on discharge.
3.08 Identify alternatives to the hold, such as community and family supports, and reasons for using or not using these alternatives.

3.09 Identify the individual's needs, such as safety, medical and physical needs, to secure personal property, pets, cars, other family members, dependent children.
3.10 Identify strengths (e.g., problem solving capacities, capacity to engage others, interests and motivations, awareness of strengths and limitations, symptom management abilities).
3.11 Include information about involvement with support systems (e.g., family, friends, agencies).
3.12 Address issues relevant to the client's ethnicity, social class, religion, gender and sexual orientation, generational, and other cultural considerations, and be linguistically appropriate.
8.01 Discharge decisions should be informed by a validated instrument whenever possible.
8.02 Discharge decisions should be based on a documented, systematic review of interventions that have previously benefitted the detained individual.
8.05 Include family members and significant others as identified by the client.
8.06 Focus the discharge process on post-discharge follow-through.

- Use existing resources, such as the LPS Clinical Assessment Guidelines and the milestones of recovery scale, to describe the activities or results of implementing the Guidelines.
- Make the description of activities specific enough to explain how activities will achieve the expected effects or outcomes.
- Explain necessary cultural accommodations. For example, program descriptions might be addressed in pamphlets that are designed for lesbian, gay, bisexual, transgendered, and questioning (LGBTQ) youth to clarify how the guidelines are likely to benefit individuals of that status.

Identifying Resources within Programs Implementing LPS Clinical Assessment Guidelines

Identifying resources in programs means compiling information about facilities and personnel ranging from staff composition to meeting spaces in which program activities may be conducted. This information can include time, talent, technology, equipment, funding sources, and other assets. Some questions for consideration may include:

- What kinds of programs provide services prior to an involuntary detention that could influence the course of an involuntary detention once it occurs?
- What kinds of programs provide post-discharge services that can influence the likelihood of future involuntary detentions?
- Are the available preadmission, involuntary detention, and post-discharge resources mismatched?
- What are all the direct and indirect program inputs and costs related to LPS Clinical Assessment Guidelines implementation?

Implementation Strategies

- Be specific about resources. If staff persons constitute a key resource, specify the functions and capabilities of staff members (e.g., inpatient physicians, nurses, social workers, out-patient staff, law enforcement officers), how many staff members are available, and how much of their time is needed to implement LPS Clinical Assessment Guidelines. Describe the necessary staff qualities or the training of staff that are essential elements of guideline implementation.
- Identify resources that are linked to success in working with unserved or underserved populations such as the staff's linguistic capabilities and other relevant aspects of cultural competency and cultural humility 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 guidelines to determine the existence of any mismatches between resources and activities. Such discrepancies could explain why expected effects are not achieved.

Examples of Resources Relevant to LPS Clinical Assessment Guidelines Implementation

- Funding
- Staff
  - ◊ administrative and managerial personnel
  - ◊ direct service providers, including psychiatrists, psychotherapists, and case managers
  - ◊ specialized staff members, with bilingual, bicultural, information technology, or other expertise
- Community services
  - ◊ administrative and managerial personnel
  - ◊ direct service providers, including first responders, transportation providers, physical healthcare service providers and providers of housing resources
  - ◊ specialized staff members with bilingual, bicultural, information technology, or other expertise
- Family members and caregivers
- Resources from allied service delivery systems, such as:
  - ◊ vocational training resources

- ◊ physical health-related resources such as primary care physicians, dentists, and nurses
- ◊ organizational resources (e.g., Law Enforcement, NAMI, Area Agency on Aging)
- ◊ suitable post-discharge placements

- 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 changing maturity or program practices of the LPS Clinical Assessment Guidelines Implementation Project during the evaluation process.

Definition

A program's stage of development reflects its maturity. Understanding the stages of development *of the program* helps to define the goals of the evaluation. What is the developmental stage of an organization change project? Its stage in planning, implementation, or effects defines the goals of evaluation. A project in its planning phase might use evaluation to refine its plans. A project in its implementation phase might use evaluation to improve operations. During evaluation phase, the goal might be to identify and explain the intended and unintended effects of the project. This section is useful for determining the changing maturity or program practices impacted by the LPS Clinical Assessment Guidelines during the evaluation process.

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, 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. This is not a stage of terminating guideline usage but of the special efforts needed to facilitate adoption of the guidelines.
- 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.

Considering the Context of the LPS Clinical Assessment Guidelines in Program Descriptions

Considering the context of the LPS Clinical Assessment Guidelines 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 programs using involuntary detention operate. 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 LPS Clinical Assessment Guidelines that go beyond the services' using involuntary detention. These are components also hypothesized to affect the intended outcomes, such as the following.

- Social support networks for clients are contextual to an individual's involuntary detention experience because individuals within these networks influence clients. An important social ecology of behavioral 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.
- Organizational culture and climate (e.g., supervisor support, cooperation and collaboration internally and across partner agencies, leadership, staff burnout) are potentially strong determinants of outcomes.
- Inter-organizational relationships are important contextual factors for programs, particularly those that are inter-dependent for clients and resources. For instance, psychiatric emergency and inpatient programs are systems driven. Their admission rates and their clients' clinical status and expectations are greatly influenced by the effectiveness of outpatient services and local law enforcement practices.

- Neighborhood and community factors affect programs directly and indirectly. Psychiatric emergency and inpatient programs operate in communities; therefore, describing the community (e.g., its support of lack thereof for community behavioral health) is essential in understanding the program. For example, administrators of programs using involuntary detention that serve an ethnic minority group in a community known for housing or employment discrimination should seriously consider this context in implementing the program.
- Political factors (e.g., local, statewide, national) influence not only program funding but also program practice, regulatory requirements, and evaluation.

- Consider the relationship of programs that use involuntary detention to other programs or practices in describing how those programs interact with countywide or statewide initiatives. As more and more recovery-oriented values are being integrated into systems-wide initiatives, the use of LPS Clinical Assessment Guidelines based on those values becomes incrementally less isolated.

Developing a Logic Model for Guideline Implementation

Logic models help to create a visual depiction that capture the key elements of a program. The process of *developing a logic model for programs for guideline implementation* includes creating a program's road map, typically in the form of a flowchart, 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. This tool identifies what works and why in the process of documenting expected effects or outcomes.

Implementation Strategies

Use 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, whereas 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. 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 diverse stakeholders in the development of the logic model to verify the accuracy of the information used.
- Use the logic model to strengthen any claims of causality by linking the causal chain when expected effects are not directly measured.
- 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.

Example of a Logic Model

This example of a theory of change logic model for a generic recovery model program was developed by Mental Health America Los Angeles for the MHA Village Program for Adults in Los Angeles County.

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 the endeavor. Different inputs result in different program cultures in which the general practices (therapeutic relationship and organizational factors like a welcoming environment) and the specific practices (treatments and services) are embedded. Effective practices 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 of employment.

In this model, practices can directly affect 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 renting an apartment can produce an experience of hope.

Resource Guide

Each of the tools listed below has specific resources that you can locate in the general resource section. This guide enables you to focus on the pertinent resources linked directly to each tool.

Name of Tool	Resource Number(s)
Developing a Statement of "Need"	1, 2
Defining the Expected Effects of Implementing the Guidelines	3,10
Understanding the Stages of Development	4, 9
Developing a Logic Model for Programs	5, 6, 7, 8

Resources

Books

1. Carlson, M., T. O'Neal-McElrath, and The Alliance for Nonprofit Management. *Winning Grants Step by Step* (3rd ed.). San Francisco, CA: Jossey-Bass; 2008).

2. Coley, S. M., and C.A. Scheinberg. *Proposal Writing: Effective Grantsmanship* (3rd ed.). Thousand Oaks, CA: Sage Publications; 2008.

3. Friedman, M. *Trying Hard Is Not Good Enough: How to Produce Measurable Improvements for Customers and Communities.* Victoria, BC, Canada: Trafford; 2005.

4. McDonald, S. "Scale-up as a framework for intervention, program, and policy evaluation research." In G. Sykes, B. Schneider, and D. N. Plank (Eds.), *Handbook of Education Policy Research* (pp. 191–208). New York, NYY: Routledge; 2009.

Guidebooks

5. Anderson, A. A. *The Community Builder's Approach to Theory of Change: A Practical Guide to Theory Development.* The Aspen Institute Roundtable on Community Change; n.d.. Available: http://www.aspeninstitute.org/sites/default/files/content/docs/roundtable%20on%20community%20change/rcccommbuildersapproach.pdf

6. Kellogg Foundation Logic Model Development Guide. Battle Creek, MI: W.K. Kellogg Foundation; 2004. Available: http://www.wkkf.org/knowledge-center/resources/2006/02/WK-Kellogg-Foundation-Logic- Model-Development-Guide.aspx

7. Knowlton, L. W., and C. C. Phillips. (Eds.). *The Logic Model Guidebook: Better Strategies for Great Results*. Thousand Oaks, CA: Sage Publications; 2008.

Online Course

8. Enhancing Program Performance with Logic Models (online course developed by the University of Wisconsin). Available: http://www. uwex.edu/ces/lmcourse/

Manuals

9. Fixen, D. L., S. F. Naoom, K. A. Blasé, R. M. Friedman, and F. Wallace. *Implementation Research: A Synthesis of the Literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231); 2005.

10. United Way of America. *Measuring Program Outcomes: A Practical Approach.* Alexandria, VA; 1996.

To focus the evaluation is to be clear about its purpose because such clarity sets the stage for generating the evaluation questions and study design. Based on the CDC Framework for Evaluation in Public Health, the function of conducting evaluations serves four general purposes: (a) gain insight, (b) change practice, (c) assess effects, and (d) affect evaluation participants and audiences.

The former 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. The initial two, addressed in this domain, are county responsibilities. (CMHPC 2010)

Gaining Insight

The process to determine the feasibility of adopting a new approach and to clarify how activities will be designed to achieve expected outcomes is called *gaining insight.*

Knowledge obtained from an evaluation focused on *gaining insight* could reveal important information on, for example, the practicality of adopting a new approach to involuntary hospitalizations. 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).

Implementation Strategies

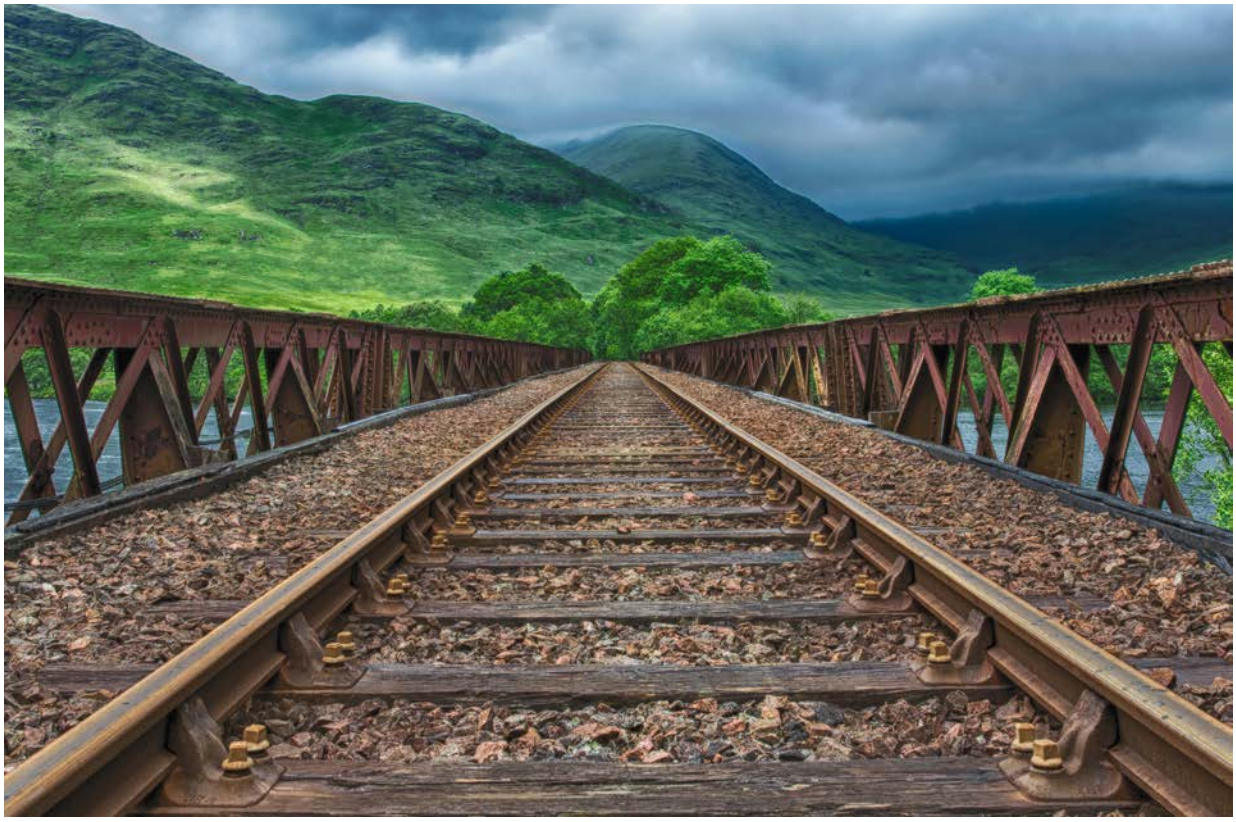
- Conduct evaluations with the purpose of gaining insight as part of the process of developing a new program or adding a new program activity to an existing program.

Changing Practice

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 innovation such as the LPS Clinical Assessment Guidelines is being newly implemented, for example, this is a good time to start an evaluation of the project intended to change practice. This type of evaluation is often designated a "formative" evaluation, or one that is intended to generate knowledge that could be used for program development and improvement.

Examples of evaluation for the changing practice may include:

- Refining plans for introducing new guidelines to an existing emergency or inpatient service
- Characterizing the extent to which plans for introducing the guidelines were implemented
- Setting priorities for staff training
- Making midcourse adjustments to improve staff engagement during the guidelines implementation project
- Determining what staff knowledge and which staff skills can most effectively be improved
- Mobilizing community support for a program.



Implementation Strategies

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

- Monitor fidelity of the guideline implementation project to the plan for that project. Each implementation project should be based on a practice model. Using a logic model of the implementation project, monitor its fidelity in terms of whether implementation is proceeding as intended and depicted in the logic model. Fidelity studies help not only to show the extent to which implementation is true to the project's design, but also to explain the outcomes.
- Examine staff practices that are relevant to guideline implementation. Look at the LPS Clinical Assessment Guidelines Toolkits to identify the core practices of effective guideline implementation. Assess these practices as part of quality assurance and/or improvement activities and use the evaluation findings to understand why training outcomes were or were not achieved.
- Consider the role of family members and other supports. 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.
- Study staff composition with respect to guideline implementation goals. This approach helps to determine disparities in staff learning and skill acquisition by profession, prior education, or prior experience. For example, guidelines calling for articulating major decisions in clinical documentation may require different kinds of training for staff with various levels of education.
- Assess the operational environment of guideline implementation. The operational environment might explain variations in outcomes of the implementation project. 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 of the program providing services during involuntary detention because they have a decided impact on program outcomes. Measure these constructs as a way to understand the organizational context of project outcomes. For example, 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 or of following through on regular use of their own chosen medications.

- Explore “community connectedness.” The behavioral health service delivery system operates within a larger context of community resources such as churches, nonprofit organizations, and foundations unaffiliated with the formal system.
- Evaluate the effects of the guidelines implementation project on other programs and practices. For example, explore how the development of the guidelines related to knowledge and skills influence change in outpatient case management services.
- Examine unintended consequences. Some staff trained as part of a guidelines implementation project, for example, may experience a ceiling effect on their level of knowledge or skills. They may be unwilling to engage in shared decision-making if they are concerned about being held responsible for the consequences of a client's decisions if there are no agency policies or laws providing them with immunity from liability. An evaluation that explores such deterrents could shed light on why guideline implementation is weaker than anticipated.
- Consider economy of scale to develop evaluation questions that build upon existing evaluation efforts. If other evaluations are taking place in the service system, borrow ideas about evaluation questions, measures, and other elements.

Example I

The purpose of this evaluation is to explore the reasons why staff effectively complete or don’t compete the training provided in a guidelines implementation project.

Sample evaluation questions:

1. How many staff members are assigned to attend LPS CAG Guidelines implementation training?
2. For what reasons do staff engage in the offered training?
   To what extent do supervisors, middle managers, and administrators participate in the training along with line staff? How does such conjoint participation correlate with staff learning, skill development, and attitude change?

Assessing Effects

Assessing Effects, a type of evaluation appropriate for well-established programs, can define which interventions were delivered to what proportion of the target population. This type of evaluation (i.e., summative evaluation) is intended to gather Information that could be used for decisions about program continuation, expansion, and elimination.

Summative evaluations are designed to make a judgment on 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 evaluation of a program 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 assessing effects may include:

- Assessing post-discharge engagement in follow-up services listed in a client's discharge plan
- Determining which kinds of clients respond most favorably to practices that are based on the guidelines
- Assessing changes in service provider behavior over time
- Comparing costs with benefits
- Determining how guideline implementation affects a program's compliance with other accountability requirements
- Gathering success stories.

(Patton 2010)

Implementation Strategies

- Examine intended outcomes for guidelines implementation, including those identified in the logic model. The typical outcome considerations for guidelines implementation post-discharge follow through on service referrals, living situation, physical and mental health, reduced rates of re-hospitalization, and assumption or resumption of meaningful life roles. View these outcomes within a paradigm of recovery and resiliency. For example, ask evaluation questions regarding strengths and resources for clients and their support networks. Additionally, consider all these outcomes within a community network of relevant services that involves physical health services, housing services, vocational training, law enforcement, probation, and self-help networks.
- Build upon the work of others. Personnel from county-level programs throughout California have devised numerous questions for use in evaluating their programs. For example, information on the rate of housing stability, education, and employment (important aspects of the recovery model) is being collected.
- Examine unintended consequences. For example, is there a decrease in outpatient revenues because of greater involvement of outpatient staff during a client's involuntary detention (which may be considered a duplication of services by third-party payers)? Is there an increase in re-hospitalizations due to the possibility that involuntary detentions based on LPS Clinical Assessment Guidelines might be less aversive by clients?

Affecting Participants

Affecting participants refers to using the process of evaluation inquiry to influence clients 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 involuntarily detained individuals (e.g., increase a client's sense of influence over program direction), to promote staff development (e.g., teach staff how to collect, analyze, and interpret evidence), to contribute to organizational growth (e.g., clarify how guidelines implementation relates to the organization's mission), or to facilitate social transformation (e.g., advance 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
  - sorting through and prioritizing questions with stakeholders
  - clarifying questions so that they are measurable and meaningful (including culturally meaningful)
  - fostering stakeholders' sense of ownership of the evaluation.
- Avoid mistakes in developing or narrowing the list of potential evaluation questions, such as:
  - 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
  - if the program is like all other programs.

Resource Guide

Each of the tools listed below has specific resources that you can locate in the general resource section.. This guide enables you to focus on the pertinent resources linked directly to each tool.

Name of Tool	Resource Number(s)
Gaining Insight	1, 2, 4, 5
Changing Practice	6, 14
Assessing Effects	2, 3, 7, 8, 9, 10, 11, 13
Affecting Participants	12

Resources

Books

1. Patton, M. Q. *Utilization-Focused Evaluation: The New Century Text* (3rd ed.). Thousand Oaks, CA: Sage Publications; 1997.
2. Patton, M. Q. *Developmental Evaluation: Applying Complexity Concepts to Enhance Innovation and Use.* New York, NY: Guilford, 2010.
3. Ralph, R. O., K. Kidder, and D. Phillips. *Can We Measure Recovery? A Compendium of Recovery and Recovery-Related Instruments*. Cambridge, MA: Human Services Research Institute; 2000. Available: http://www.tecathsri. org/pub pickup/pn/pn-43.pdf.
4. Rossi, P., M. Lipsey, and H. Freeman. *Evaluation: A Systematic Approach* (7th ed.). Thousand Oaks, CA: Sage Publications, 2004..
5. Scriven, M. *Evaluation Thesaurus* (4th ed.). Newbury Park, CA: Sage Publications, 1991.

Data Collection Instrument

6. ACT Fidelity Scale—A Modified Scale Based on the Dartmouth Assertive Community Treatment Scale (DACTS); n.d. Available: http://www.ncebpcenter.org/pdfs/ACTFidelityScale.pdf

Indicators

7. Meisel, J. *Performance Indicators for Evaluating the Mental Health System*. Sacramento, CA: California Mental Health Planning Council; 2010. Available: http://www.dmh.ca.gov/Mental_Health_Planning_Council/docs/PerformanceIndicatorProposalfinal.pdf

Recovery Measures in Use in California

8. Fisher, D., D. Pilon, S. Hershberger, G. Reynolds, S. LaMaster and M. Davis. Psychometric properties of an assessment for mental health recovery programs. *Community Mental Health Journal*, *45*: 246–250; 2009. Available: http://www.springerlink.com/openurl.asp?genre=article&id=doi:10.1007/s10597-009-9213-8
9. Level of Care Utilization System (LOCUS) for Psychiatric and Addiction Services. Available: http://www.communitypsychiatry.org/publications/clinical_and_administrative_tools_guidelines/locus.aspx
10. Mental Health America of Los Angeles. Milestones of Recovery Scale (MORS). Available: http://www.milestonesofrecovery.com

Report

11. Preskill, H., and N. Jones. *A Practical Guide for Engaging Stakeholders in Developing Evaluation Questions*. Robert Wood Johnson Foundation Evaluation Series; 2009. Available: https://folio.iupui.edu/bitstream/handle/10244/683/091022.stakeholder.involvement.fullreport.draft. pdf sequence=2

Report Generator

12. Mental Health America of Los Angeles. The Milestone of Recovery Scale (MORS) Report Generator. Available: www.milestonesofrecoveryscale.com

Resource Kit

13. The ACT Implementation Resource Kit. Available: http://www.ncebpcenter.org/pdfs/ACTProtocol.pdf

Designing an Evaluation, Identifying Indicators, and Selecting Sources of Evidence

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.

Designing an Evaluation

The purpose of designing an evaluation is to obtain appropriate information based on the stakeholders' requirements. 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 regarding the outcome of interest are measured. If a difference in outcome is found, it has likely been 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 like 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 chapter contains an entry for an article that supports quasi-experimental designs over the gold standard of experimental design. (Number 11)

(3) Non-experimental (or observational) designs use comparisons within a group to explain unique features of its members (e.g., comparative case studies, 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 program evaluation studies use non-experimental designs such as the one-group pretest-posttest design. For example, finding out whether engagement in outpatient services improve after involuntary detention at an inpatient service that has a high fidelity to the LPS Clinical Assessment Guidelines. 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 to gauge the ranking of the design selections in the hierarchy of evidence.

The following table presents the rating system for evidence-based practices and is based on the guidelines major institutions, including the Institute of Medicine (http://www.iom.edu/) and the Substance Abuse and Mental Health Services Administration (http://www.samhsa.gov/), have established for characterizing a practice as evidence based.

Rating	Criteria
Well Supported	1. No clinical or empirical evidence or theoretical basis indicates that the practice constitutes a substantial risk of harm to those receiving it, as compared to its likely benefits. 2. More than one rigorous randomized controlled trial has been conducted using valid outcome measures, and they have obtained consistent outcomes (positive effects with statistically significant results) in more than one setting and/or with more than one population. 3. The practice can be replicated. 4. Fidelity measures exist or can be developed from available information.

Supported	1. No clinical or empirical evidence or theoretical basis indicates that the practice constitutes a substantial risk of harm to those receiving it, as compared to its likely benefits. 2. At least one rigorous randomized controlled trial has been conducted using valid outcome measures, and they have identified positive effects with statistically significant results. 3. The practice can be replicated. 4. Fidelity measures exist or can be developed from available information.
Promising	1. No clinical or empirical evidence or theoretical basis indicates that the practice constitutes a substantial risk of harm to those receiving it, as compared to its likely benefits. 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.
Emerging	1. No clinical or empirical evidence or theoretical basis indicates that the practice constitutes a substantial risk of harm to those receiving it, as compared to its likely benefits. 2. The practice has sound theoretical rationale and has been shown to be related to positive change through a minimum of a pre/post-evaluation using valid outcome measures.

- 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.
- Avoid packing a comprehensive evaluation into a simple design. Involuntary detentions are complex, in part because they are usually embedded in a multifaceted service delivery system. This means that the evaluation design should be multifaceted. For example, evaluate a client's post-discharge functioning based on perspectives from a client's outpatient psychiatrist, case manager, significant others, and the client.

Identifying Indicators

Identifying indicators helps to establish criteria for measuring different aspects of a program. Indicators are program aspects 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

- See Module 1 for examples of indicators relevant to most of the LPS Clinical Assessment Guidelines.
- Identify indicators that can be defined and tracked for measuring program activities (e.g., process measures, fidelity to the guidelines) and program effects (e.g., outcome measures, desired effects on the client's mental status and social functioning).
- 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. There's a risk of too many possibilities and variables. Use the logic model to define the highest priority indicators.
- 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.
- Establish a common definition for indicators with service partners. For example, "What is the definition of "stable housing" that clients, significant others, and service providers can agree upon?"

Selecting Sources of Evidence

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 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 adherence to the LPS Clinical Assessment Guidelines. 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 a program.
- Use existing data to reduce or eliminate the need to collect new data for evaluation— doing so can be beneficial for smaller counties in particular—but do not tailor evaluation questions toward existing data simply because the data are readily available.
- Integrate quantitative and qualitative information to potentially increase the chances that the evidence will be balanced, thus meeting the expectations of diverse stakeholders.
- Seek data directly from the service delivery systems that collect the data. Departments of behavioral health may not have access to housing, income, or law enforcement data

Ensuring Quality of Evidence

Involving stakeholders in the evaluation process creates a method for *ensuring quality of evidence*. The aim is to meet the stakeholders threshold for credibility and to ensure evidence with a level of quality that meets said threshold

"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 or design high-quality instruments. Refer to the "Identifying Indicators" tool for more information on reliability and validity.
    - Choose measures that have already been tested for reliability or validity (i.e., psychometric properties). 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, and development of instruments for use with diverse ethnic and cultural groups. Be aware that many instruments have not been tested with multiple ethnic and cultural groups. Unless the instruments were developed with ethnic groups in mind, chances are high that it has not been tested across various ethnic groups.
- Consider appropriate data collection procedures. Refer to the "Considering the Logistics of Data Collection" tool in the resource section (9, 12, 13, 14). Think through data collection procedures before committing to a data source.
- 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.
- Select multiple sources of evidence. Refer to the "Selecting the Sources of Evidence" tool.
- 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.
- Before beginning, identify who should be responsible for the quality and management of data.

- Perform routine error checking. Use strategies implemented by numerous counties for cleaning data by the following.
    - Apply a “tickler” system to track and clean data. This system flags data that are outliers.
    - Consider regularly sharing with a service provider a single data element (e.g., living situation) that can be reviewed for suspicious data. Focusing on one or a few data elements at a time makes the data-cleaning task more manageable.
    - Develop a system for sharing reports with service providers.
    - Generate monthly reports on key event tracking (KET) data for individual clients as a way to verify the data that providers have submitted.
    - Develop criteria for determining when data should be questioned or considered suspicious. For example, most hospitalizations last fewer than 10 days; therefore, an analyst might reasonably scrutinize all hospitalizations of more than 15 days to identify possible errors in data recording.
- 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. Inevitable trade-offs (e.g., breadth versus depth) should be negotiated among stakeholders.

Determining Quantity of Evidence

"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; identifying 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 and respondents.
- Estimate in advance the amount of information and the time to gather the information required. The burden on persons to provide and collect information should always approach the minimum needed.
- Take a sample that is representative of the group. If the group is large (e.g., all involuntarily detained clients since adoption of the guidelines) and one wants to conduct interviews, do not try to include everyone in the group.

Considering the Logistics of Data Collection

This section is useful to plan the process of collecting data. 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 some cultures the *collective* outcome typically holds greater value than the *individual* outcome. In some cultures, psychosomatic troubles are commonly manifested and discussed as physical problems.
- Consider how culture influences decisions about whom would be perceived as an appropriate person to present questions when gathering information.
- 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.
- Set a realistic time frame for data collection. Evaluations take time. Evaluations that involve stakeholders in the evaluation process take even more time.

Resource Guide

Each of the tools listed below has specific resources that you can locate in the general resource section. This guide enables you to focus on the pertinent resources linked directly to each tool.

Name of Tool	Resource Number(s)
Designing an Evaluation	1,4,5,7,11,13, 20
Identifying Indicators	2,6,7,13,15
Selecting the Sources of Evidence	4,5,7
Ensuring Quality of Evidence	3,8,10,16,17,18, 19,20
Determining Quantity of Evidence	13
Considering the Logistics of Data Collection	9,12,13,14

Resources

Articles

1. Begley, S. The Best Medicine: Cutting Health Costs with Comparative Effectiveness Research. *Scientific American*, *305*: 50; 2011. Available: http:// www.scientificamerican.com/article.cfm?id=the-best-medicine-july-11
2. SenGupta, S., R. Hopson, and M. Thompson-Robinson. *New Directions for Evaluation* (Special Issue: In Search of Cultural Competence in Evaluation: Toward Principles and Practice), 102. San Francisco, CA: Jossey-Bass, 2004.

Books

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5. Denzin, N. K., and Y. Lincoln. (Eds.). *Handbook of Qualitative Research* (2nd ed.). Thousand Oaks, CA: Sage Publications; 2000.
6. Devellis, R. F. *Scale Development: Theory and Applications* (2 ed.). Thousand Oaks, CA: Sage Publications; 2003.
7. Kumar, R. *Research Methodology: A Step-by-Step Guide for Beginners* (2nd ed.). Thousand Oaks, CA: Sage Publications; 2005.
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9. Phillips, J. J. *Handbook of Training Evaluation and Measurement Methods* (3rd ed.). Houston, TX: Gulf Publishing Company; 1997.
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14. Weller, S. C. *Systematic Data Collection.* Thousand Oaks, CA: Sage Publications, 1988.

Indicators

15. Meisel, J. (2010). *Performance indicators for evaluating the mental health system*. Sacramento, CA: California Mental Health Planning Council. Available: http://www.dmh.ca.gov/Mental_Health_Planning_Council/docs/PerformanceIndicatorProposalfinal.pdf

Validated Instruments

16. ACT FIDELITY SCALE:

    A Modified Scale Based on the Dartmouth Assertive Community Treatment Scale (DACTS). Available: http://www.ncebpcenter.org/pdfs/ ACTFidelityScale.pdf

17. LOCUS—Level of Care Utilization System:

    For Psychiatric and Addiction Services. Available: http://www. communitypsychiatry.org/publications/clinical_and_administrative_tools_ guidelines/locus.aspx

18. MORS—Milestones of Recovery:

    Fisher, D., D. Pilon, S. Hershberger, G. Reynolds, S. LaMaster, and M. Davis. Psychometric Properties of an Assessment for Mental Health Recovery Programs. *Community Mental Health Journal*, *45,* 246–250; 2009. Available: http://www.springerlink.com/openurl.asp?genre=articleandid=doi:10.1007/s10597-009-9213-8

19. Substance Abuse and Mental Health Services Administration (SAMHSA)—Evidence-Based Practices. Available: http://www.samhsa.gov/

Website

20. Erickson, F., and J. Straceski. *A Quality of Heart: Continuity, Change, and Distinctiveness in Service Delivery at the Village, ISA*. Los Angeles, CA: Graduate School of Education and Information Studies, UCLA; 2004. Available: http://mhavillage.org/informationmedia/quality_of_heart.pdf

Chapter 6: Analyze and Draw Evaluative Conclusions in Data Analysis

Data Analysis

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:

a) Examining the findings against agreed-upon standards;

b) Interpreting or giving meaning to the findings;

c) Judging a program or performance or making claims of merit, worth, or significance;

d) Recommending actions.

Preparing for Data Analysis

Preparing for data analysis involves more than organizing the data and deciding on the analytic technique. Because data analysis requires technical expertise, electronics and software, gathering the resources for these requirements is a vital 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.
  - Focus the analysis on prioritized indicators for the five major outcomes identified in the logic model.
  - Let the performance indicators for evaluating the behavioral health system guide decisions on prioritizing data analysis, as well as decisions on data analysis and reporting.
  - Determine the priority groups and subgroups for analyzing disparities in access and outcomes. For example, if the involuntary detentions occur in a multiethnic community, the analysis should place high priority on examination of data relevant to outcomes across ethnic groups. If the program is focused on children/youth or older adults, the

analysis should place high priority on examination of outcomes across age subgroups.

- Partner with service providers to analyze the data. Counties and contract providers can use each other as resources for data analysis; two or more providers likewise can exchange information.
- Partner with other county departments and community-based partners such as faculty in local universities to assist with data analysis. Doing so is especially helpful for small counties or counties with limited evaluation resources.
- 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.
- Determine all the units of analysis before conducting data analysis. That preparation is especially important for programs that involve clients and significant others, the program unit (i.e., partner programs or agencies), and the system unit (i.e., allied service delivery systems such as welfare, probation, health, and vocational services).

Conducting Quantitative Data Analysis

The purpose for conducting quantitative data analysis is to ensure the ability to provide appropriate data findings. The process involves preparation of the data with a basic understanding of WHY, WHEN and HOW an analytic technique is used. Computer 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.
- 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:

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

- 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 codes (e.g., 0, 1, 2) the presence of a 5 in the data would be erroneous
- 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 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 because 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.

- *Interval measures* have meaningful standard intervals, but 0 is arbitrarily defined in interval measures and does not mean the complete absence of something. For example, 0 on the Celsius scale is defined as the point at which water freezes. However, someone who scores a 0 on an IQ test could not be regarded as devoid of intelligence.
- *Ratio measures* have a true 0 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*; consider whether the sample size may be too high or too low. 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 toolkit, three basic techniques are appropriate to consider: univariate analysis, bivariate analysis and multivariate analysis.
  - *Univariate analysis* is the examination of the distribution of cases one variable at a time. Frequency distributions, percentages, and averages are commonly used in univariate analyses.
  - *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, similar to the univariate analysis method. Suppose, for example, that a provider wants to know how many adult male and female clients were ever incarcerated before involuntary detention in an inpatient program with high fidelity to the LPS Clinical Assessment Guidelines. Depending on the level of measurement of the data, the findings can be presented in the following ways:

Example of Frequency Distribution and Percentage for Two Variables at a Time		
	Female (sample size = 200)	Male (sample size = 250)
Ever incarcerated	50 or 25% of all females	100 or 40% of all males
Never incarcerated	150 or 75% of all females	150 or 60% of all males
Example of Means for Two Variables at a Time		
	Female (sample size = 200)	Male (sample size = 250)
Total number of incarcerations prior to involuntary detention	Mean = 1.5 (Standard deviation = .5) (Range of 0 to 5)	Mean = 3.2 (Standard deviation = .97) (Range of 0 to 7)

- *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 involuntary detention; however, the provider also 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:

Example of Frequency Distribution and Percentage for Three Variables at a Time				
	Under 30		30 and Over	
	Female	Male	Female	Male
Ever incarcerated	15 or 13%	75 or 65%	35 or 41%	25 or 18%
Never incarcerated	100 or 87%	40 or 35%	50 or 59%	110 or 82%
Sample size	115	115	85	135

- Use inferential statistics. Describing the sample is an important first step in presenting the evaluation findings. However, to make assertions about the larger population the sample represents, or to explain the causal processes of the relationships observed in the data, statistical techniques (i.e., inferential statistics) are used. The logical bases for inferential statistics are too lengthy to cover in this toolkit, and such analyses should be conducted by individuals well versed in this issue.

Applying Statistical Techniques to Evaluations

Applying statistical techniques to 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 following segment of this tool.

Implementation Strategies

- Select the appropriate tests of statistical significance. Tests or techniques useful for analyzing 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 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 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 1 year by projecting calculations to represent a 12-month period. The annualized numbers are not true values; therefore, make certain to explain in reports and to stakeholders whether findings are based on annualized data.
- Compare data from multiple informants.

Drawing Evaluative Conclusions

It is important to justify conclusions against agreed-upon standards set by the stakeholders. Common steps to *draw evaluative conclusions* include:

(a) examining the findings against agreed- upon standards; (b) interpreting the findings;

(c) judging a program or performance, or making claims of merit, worth, or significance

(d) recommending actions based upon evaluation findings

Implementation Strategies

- Use culturally appropriate methods of analysis and synthesis to summarize findings. Involve stakeholders in deducing meaning from data.
- Interpret the significance of results for deciding what the findings mean. Keep in mind that statistical significance and practical significance differ from one another.
- Make judgments per 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, or past performance. Such considerations facilitate quality improvement measures by defining the meaning of the finding. Is a 10 percent increase in post-discharge referral follow-through a positive or negative finding? If clients from low fidelity inpatient services have a 20 percent increase in this measure during the same time frame, it's a negative finding. If clients from low fidelity inpatient services have no increase in this measure during the same time frame, it's a positive finding.
- 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. 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.

Resource Guide

Each of the tools listed below has specific resources that you can locate in the general resource section. This guide enables you to focus on the pertinent resources linked directly to each tool.

Name of Tool	Resource Number(s)
Preparing for Data Analysis	6, 7, 8, 9, 11, 12, 13, 14, 15, 16
Conducting Quantitative Data Analysis	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 15
Applying Statistical Techniques to Evaluations	22, 23, 24
Drawing Evaluative Conclusions	17, 18, 19, 20, 21

Resources

Books

1. Corder, G. W., and D. I. Foreman. *Nonparametric Statistics for Non-Statisticians: A Step-by-Step Approach.* San Francisco, CA: Wiley; 2009.
2. Montcalm, D., and D. Royse. *Data Analysis for Social Workers.* Boston, MA: Allyn and Bacon; 2001.
3. Newton, R. R., and K. Erik. *Your Statistical Consultant: Answers to Your Data Analysis Questions.* Thousand Oaks, CA: Sage Publications, 1999.
4. Sirkin, M. *Statistics for the Social Sciences* (3rd ed.). Thousand Oaks, CA: Sage Publications; 2006.
5. Wagner, W. E., E. Babbie, E., F. S. Halley, and J. Zaino. *Adventures in Social Research: Data Analysis Using IBM SPSS Statistics*. Thousand Oaks, CA: Sage Publications; 2010.

Computer Software (freeware annotated with an asterisk)

6. Dedoose Software for Qualitative and Mixed-Methods Research. Manhattan Beach, CA: SocioCultural Research Consultants, LLC; 2010. Available: http://www.dedoose. com

7. *MicrOsiris statistical analysis and data management software." Derry, PA: Van Eck Computer Consulting. Available: http://www.microsiris.com/

8. *OpenEpi open-source epidemiologic statistics for public health." Available: http://www.openepi.com/OE2.3/Menu/OpenEpiMenu.htm

9. *PSPP statistical analysis software (replicates SPSS)." Available: http://www.gnu.org/software/pspp/

10. *Raosoft sample size calculator." Herndon, VA: Vovici Corp. Available: http://www.raosoft.com/samplesize.html

11. SAS business analytics software." Cary, NC: SAS Institute Inc. Available: http://www. sas.com/software/

12. *Statext statistics in text mode." Available: http://www.statext.com/ index.htm

13. Statistical Package for the Social Sciences (SPSS) predictive analytics software. Armonk, NY: IBM Corporation. Available: http://www-01.ibm.com/software/ analytics/spss

14. *Statistics Open for All (SOFA) open-source statistics, analysis, and reporting software." Available: http://www.sofastatistics.com/home.php

Reports

15. Meisel, J. *Performance Indicators for Evaluating the Mental Health System*. Sacramento, CA: California Mental Health Planning Council; 2010. http://www.dmh.ca.gov/Mental_Health_Planning_Council/docs/PerformanceIndicatorProposalfinal.pdf

16. UCLA Center for Healthier Children, Youth and Families. *Evaluation Brief: Summary and Synthesis of Findings on Consumer Outcomes*; 2011. Available: http://mhsoac.ca.gov/Meetings/docs/Meetings/2011/May/OAC_052611_Tab8_UCLAEvalBrief.pdf

Standards

17. Gostin, L., and J. M. Mann. Towards the development of a human rights impact assessment for

the formulation and evaluation of public health policies. *Health and Human Rights*, *1*, 59–80; 1993.

18. Joint Committee on Standards for Educational Evaluation. *Program Evaluation Standards: How to Assess Evaluations of Educational Programs* (2nd ed.). Thousand Oaks, CA: Sage Publications; 1994.

19. McKenzie, J. F. *Planning, Implementing, and Evaluating Health Promotion programs: A Primer*. New York, NY: Macmillan; 1993.

20. Patton, M. Q. Utilization-Focused Evaluation: The New Century Text (3rd ed.). Thousand Oaks, CA: Sage Publications; 1997.

21. Scriven, M. Minimalist theory of evaluation: The least theory that practice requires." *American Journal of Evaluation*, *19*(1), 57–70; 1998.

Training and Workshops for Evaluation

22. Professional Development Workshop Series in Evaluation and Applied Research Methods, presented by Claremont Graduate University School of Behavioral and Organizational Sciences. Available: http://www.cgu.edu/ workshops

23. Program Development and Evaluation Curriculum, presented by University of Wisconsin Extension. Available: http://www.uwex.edu/ces/pdande/ progdev/index.html

24. Summer Evaluation Institute, jointly presented by the American Evaluation Association and the Centers for Disease Control and Prevention. Available: http://www.eval.org/SummerInstitute11/default.asp

Web site

25. Free statistics books for online viewing and downloading, from the FreeBookCentre.net: http://www.freebookcentre.net/SpecialCat/Free-Statistics-Books-Download.html

Chapter 7: 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 throughout the evaluation process. Effective communication helps ensure 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 the 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.

Communicating Evaluation Findings

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 usage across the organization and stakeholder groups (e.g., line staff, mid-level managers, supervisors, administrators, policy makers). Then tailor the communication based on the utility of the evaluation findings to those organizational levels and stakeholder groups. Doing so both promotes evaluation use and facilitates evaluation implementation. Data accuracy and completion rates for data collection are more likely to improve when evaluation findings are useful to stakeholders who participated in data collection. The example below illustrates applications across several organizational levels.

  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. 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 to 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.

  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, changes in caseload size, workload, units of service provided, and revenues before and after implementation of the guidelines. Administrators are also likely to be interested in reports on fidelity to the LPS Clinical Assessment Guidelines. Fidelity to the guidelines provides feedback about the effectiveness of administrative efforts to disseminate this innovation at emergency services, inpatient units, and other service system components where practices have changed as a result of guideline implementation.

  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 designated desired 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 that 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., monthly, quarterly, annually). 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

- Be accurate in communicating evaluation findings. As Chapter 6 (Analyze and Draw Evaluative Conclusions in Data Analysis) indicates, conclusions drawn from evaluation findings must be consistent with the limits of the research design.

Knowing the Audience for Project Communication

The culture and characteristics of the audience are important to consider regarding knowing the audience for 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 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 Web site, 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 toolkit 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 targeted stakeholder audience. 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.

Communication and Presenting Information Using Formal and Informal Formats

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 types: formal and informal.

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
  - Email
  - 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
  - Web sites

- 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, Internet communication); and "least interactive" (e.g., memos and postcards, comprehensive written reports, executive summaries, newsletters, bulletins, brochures, 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.
- 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. 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, whether others who participated were satisfied with the services).

Developing a Dissemination Plan

"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 the 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 use evaluation findings to achieve improvements in practice.

Ensuring Effectiveness of Evaluation Reports

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 has been 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.
  - Distribute interim and final reports to intended readers in time for use. Interim reports are helpful in formal and regular communication about the evaluation findings.
  - Tailor the report content, format, and style for the audience(s) by involving audience members.
  - Include a summary of the evaluation findings.
  - Characterize the stakeholders and explaining how they were engaged.
  - Describe essential features of the program (e.g., inclusion of logic models).
  - Explain the focus of the evaluation and its limitations.
  - Include an adequate summary of the evaluation plan and procedures.
  - Include all necessary technical information (e.g., in appendices).
  - Specify the standards and criteria for evaluative judgments.
  - Explain the evaluative judgments and how they are supported by the evidence.
  - List both strengths and weaknesses of the evaluation.
  - Discuss recommendations for action with their advantages, disadvantages, and resource implications.
  - Ensure human subjects protections to mitigate possible harm and ensure confidentiality

for program clients and other stakeholders.

- Anticipate how people or organizations might be affected by the findings.
- Present minority opinions where necessary.
- Verify that the report is accurate and unbiased.
- Organize the report logically and include appropriate details.
- Avoid technical jargon.
- Use examples, illustrations, graphics, and anecdotal evidence.

Resource Guide

Each of the tools listed below has specific resources that you can locate in the general resource section. This guide enables you to focus on the pertinent resources linked directly to each tool.

Name of Tool	Resource Number(s)
Communicating Evaluation Findings	3, 4, 5
Knowing the Audience for Project Communication	10
Communicating and Presenting Information Using Formal and Informal Formats	1
Developing a Dissemination Plan	9
Ensuring Effectiveness of Evaluation Reports	2, 6, 7, 8

Resources

✓ Books

1. Alexander, M., and J. Walkenbach. *Excel Dashboards and Reports*. San Francisco, CA: Wiley; 2010.

2. Worthen, B. R., J. R. Sanders, and J. L. Fitzpatrick. *Program Evaluation: Alternative Approaches and Practical Guidelines* (2nd ed.). New York, NY: Logman; 1996.

✓ Fidelity Assessment

1. Transition to Independence (TIP) Process Training and Fidelity Assessment. Available: http://nnyt.tipstars.org/

✓ Guidebook

2. Langley, G. J., K. M. Nolan, C. L., Norman, L. P., Provost, and T. W. Nolan. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd ed.). San Francisco, CA: Jossey-Bass; 2009.

✓ Fidelity Assessment

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Glossary

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

data collection Any of various ways of gathering information, 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, 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 Results that the developers of a program intend to achieve. Because the effects of most 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 definitions of quantitative research 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 improve benefits to the organization and its stakeholders.

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

reliability 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 major entity being studied (e.g., individuals, groups, artifacts).

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

validity The extent to which something measures what it claims to measure. A valid scale would report your correct or true weight.

Appendices