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Program Effectiveness: Defining and Measuring Your Mental Health Services

Are our services making a difference? How have they directly improved our clients' lives? These are the questions that social service and child welfare agencies should ask of each of their programs.

As implied by its name, outcome effectiveness studies focus on the outcomes rather than the processes of a service. These studies examine service impact on clients at various points in a program, including at termination and follow-up.

The use of these studies has evolved from its earliest roots as a single-event study, to examining sustenance of gains in follow-up evaluations, to becoming integrated into programs as an ongoing occurrence. Just as client satisfaction has become an ongoing integrated data collection activity, so, too, should agencies strive to collect outcome effectiveness information on a regular basis.

There are several reasons for this:

1. Programs change over time. Once established as effective, do they continue to be effective?

2. Programs, through continuous quality improvement, can aim to become even more effective. How do we know that they are becoming even more effective without ongoing measurement of outcomes?

3. Ongoing outcome effectiveness measurements can be used to encourage maintenance of adequate levels of program quality.

4. Clients served changes. Does the program remain effective for the shifting population served?

5. New effectiveness measurements may become available. The instruments used to collect information regarding efficacy may become more exact and so modifications in study design will evolve as the program evolves.

Study Team

Through a team effort, effectiveness for a particular program may be defined. The team may wish to revisit the definition periodically to see if it still makes sense given the evolution of the program, populations served, shifting expectations of funders, and any other factors. Ideally, the team consists of program staff, including the director and line staff, and the evaluator or department selected to oversee the outcome effectiveness effort. The evaluator's role on the team is to continue asking the question, "What does it truly mean for this program to be effective?" The role of the program staff is to help the evaluator understand what the program is trying to achieve in real life.

Defining Effectiveness

The ideal outcome of a program may be influenced by a particular philosophical framework and viewpoint. These different perspectives enforce the great value of a uniform, agreed-upon definition of effectiveness. Consensus among team members, particularly service providers, becomes key. Program philosophies may evolve over time and may not have been codified in writing.

Measuring Effectiveness

Because there is no single, all-encompassing, objective source that can be used for assessing effectiveness, multiple sources of information are needed. Coordinating and combining information from multiple sources requires great diligence. Possible sources include service providers, service recipients, client records, management information systems, and individuals in ancillary or collateral roles.

Gathering information from multiple collateral sources is important. Data on the same variable from multiple sources, such as service providers and service recipients, will illustrate anything from complete agreement to complete disagreement. Points of divergence are of interest as they can lead, for example, to a better understanding of service recipients. Depending on the particular discrepancy that may be found, service providers may feel encouraged and validated, or be challenged to review long-standing assumptions and treatment strategies.

Excerpted from "Defining and Measuring Program Effectiveness at a Mental Health/Social Services Agency" by Miriam P. Kluger, Nelson Rivera, & Marie Mormile-Mehler. *Families in Society* © 2001. To read the complete article, log in to www.familiesinsociety.org.

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(Available at www.familiesinsociety.org)

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Clinical Social Work Practice With Urban African American Families (1998)

Mental Health Professionals' Contact With Family Members of People With Psychiatric Disabilities (2005)

The Use of a Consultant Psychiatrist in a Family Service Agency (1980)

Handling Emotional Problems in Business and Industry (1985)

Chronicity in Mental Disorders: Evolution of a Concept (1988)

Ethical Considerations in the Psychosocial Process (1988)

Social Work and the Psychiatric Nosology of Schizophrenia (1987)

Forensic Social Work: Practice and Vision (1986)

Services for Persons With Mental Illness in Jail: Implications for Family Involvement (1997)

A Family Agency Integrates Planned Short-Term Treatment (1980)

Psychopharmacology: Guidelines for Social Workers (1984)

Screening for Affective Disorders (1991)

Clinical and Ecological Approaches to the Borderline Client (1983)

Policy Focus

Outpatient Commitment for Adults With Psychiatric Disabilities: Examining the Underlying Assumptions (2002)

New York's Assisted Outpatient Treatment Act provides an opportunity to examine assumptions underlying the passage of outpatient commitment laws: mental health consumers are not competent to direct their recovery, a decision not to use formal mental health services is a symptom of the disability, the best intervention for psychiatric disability is primarily a medical one, and mental health services are universally and consistently helpful. Based on a critique of these assumptions, the author recommends future research focus on the consumer experience.

Maximizing Treatment Effectiveness in Clinical Practice: An Outcome-Informed Collaborative Approach (2005) (CE course # 100814)

Practicing clinicians can make use of both outcome and process measures to create a more collaborative and effective therapy with their clients. Methods discussed here offer practitioners the means to identify which clients are responding to treatment and those for which treatment is not working so that adjustments can be made to the therapy. The goal is to decrease dropout rates, increase levels of customer satisfaction, and document and improve the overall effectiveness of treatment.

Treatment Family Foster Care: Its History and Current Role in the Foster Care Continuum (2006)

This article reviews the historical development in the United States of treatment family foster care as an alternative to the psychiatric hospitalization or long-term residential treatment of children and youth with serious emotional and behavioral disorders. Treatment family foster care has developed in three discrete systems of care: juvenile justice, child welfare, and mental health. The authors examine the relative contribution of each of these systems to its development, its current role in the provision of services to children with emotional and behavioral challenges, and the evidence base for this form of care.

Practice Focus

A Strengths-Based Practice Model: Psychology of Mind and Health Realization (2003)

The author discusses the tenets and applications of the psychology of mind/health realization theory, stating that, although used for the past 27 years, it is still unfamiliar to many in the helping professions. It fits in well with the trend toward strengths-based practice, focusing on the client's resources and resilience, on elf-empowerment and self-help, effectiveness, and efficiency. It can be taught and implemented easily, and, among other advantages, allows a here-and-now focus on feelings of well-being rather than on painful thoughts and disturbing memories.

Early Intervention Strategies With Borderline Clients (1996)

The author discusses the treatment needs of young, self-destructive, unstable, borderline clients. A practice approach reformulated on the basis of recent research findings on borderline developmental history and course of illness is presented. This approach employs strategies derived from trauma recovery and brief treatment to address self-destructiveness and high rates of attrition in this clinic population, as well as the demands of managed mental health care for briefer, more effective treatment. Pragmatic goals and structured, focused interventions for initial contacts or the early stage of treatment are outlined.

Relational Social Work: A Model for the Future (2005) (CE course # 100809)

This article outlines and elaborates on the main features of the authors' relational model: a reconceptualization of transference and countertransference, the role of enactments in the clinical setting, the importance of the use of self, and the worker's participation as a change agent. Use of this model, according to the authors, will enhance clinical services, reduce failed treatments and therapeutic impasses, and diminish the incidence of boundary violations. They report having used it successfully in residential settings with homeless individuals, persons with chronic mental illness and substance abuse, and ex-offenders.

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Motivating Persons With Dual Disorders

Increased interest has been shown in the assessment and treatment of individuals with dual disorders—people who have coexisting psychiatric and substance-use disorders. Accurately identifying and diagnosing this population can be difficult and the challenges in working with people with dual disorders extend beyond identification and differential diagnosis to include assessment and treatment. I propose a motivational-stage approach model for helping clients accept the need for treatment for both disorders. This approach combines two models from addiction research—stages of change and motivational interviewing—and applies them to the clients' psychiatric and substance-abuse disorders. *(See below for a review of these treatment models.)*

Application of the Motivational-Stage Approach

Practitioners who work with this population often comment on clients' capacity for "double denial." As with the cases described earlier, clients can be in one stage of change with regard to one disorder and in a different stage of change for the second disorder. This model can be applied to either or both disorders concurrently.

The first step in applying these concepts is to assess where the client is with regard to the stages of change for each of the disorders. Although assessment instruments can aid in this process, when one is familiar with the stages of change, accurately assessing where a client fits on the basis of one or two clinical interviews is not difficult.

When conducting a change-stage assessment, practitioners gather information on both disorders within the context of a comprehensive biopsychosocial assessment. For substance abuse, this involves assessing each substance separately; for psychiatric disorders, it involves assessing the severity of individual symptoms and problem behaviors separately, unless the client has already identified the disorder (or collection of symptoms) as a problem, in which case his or her opinion about the whole disorder can be elicited. Throughout the assessment process, the social worker elicits the client's perception about each substance, psychiatric symptom, or problem behavior. Questions about if, when, and how clients see their substance use or psychiatric disorder (or symptom) as a problem need to be explored. Questions about how and why clients do not see disorders as problems are also important. Information about the perceptions of significant others (as well as clients' reactions to these perceptions) can clarify whether clients are in precontemplation or later stages. Obtaining information about expectations related to changing or getting help for each problem, as well as prior attempts to change, can elicit information about the current stage and about barriers encountered in past change efforts.

After the stage of change for each disorder has been identified, intervention can be chosen to fit each stage of change. Intervention matched to the appropriate stage will ideally facilitate the client's movement from one stage to the next. For example, with clients who are in precontemplation or contemplation in relation to one (or more) of their disorders, the following strategy is often helpful. Together, the client and practitioner identify a specific goal of change that the client wants to achieve, one for which he or she is in the preparation phase or at the beginning of the action phase. In the course of assessing and intervening with this desired goal, the practitioner explores how the client's psychiatric symptoms and/or substance use affects the inability to achieve this goal.

Stages of Change in Clients

1. Precontemplation
2. Contemplation
3. Preparation/determination
4. Action
5. Maintenance

Principles for Clinicians in Motivational Interviewing

1. Express empathy
2. Develop discrepancy between individuals' perceptions of where they are and where they want to be
3. Avoid argumentation
4. Roll with resistance
5. Support the client's sense of self-efficacy

Excerpted from "Motivating Persons with Dual Disorders: A Stage Approach" by Nancy J. Smyth. *Families in Society* © 1996.

Related Articles for Further Reading

(Available at www.familiesinsociety.org)

Identifying and Reducing Barriers to Reunification for Seriously Mentally Ill Parents Involved in Child Welfare Cases (2004)

The Parenting Experience of Low-Income Single Women With Serious Mental Disorders (1995)

The Prognosis for Social Work Diagnosis (1989)

Homeless Persons with Mental Illness and Their Families: Emerging Issues from Clinical Work (2000)

Innovative Therapeutic Care for Homeless, Mentally Ill Clients: Intrapsychic Humanism in a Residential Setting (2001)

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Privileged Communications for Social Workers (1988)

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Common Factors in Psychotherapy Outcome: Meta-Analytic Findings and Their Implications for Practice and Research (2004) (CE course # 100704)

Mapping Practice: Problem Solving in Clinical Social Work (1985)

Expanding the Role Repertoire of Clinicians (1987)

Qualitative Assessment: A Methodological Review (1995)

The Social Network Map: Assessing Social Support in Clinical Practice (1990)

Incorporating Recovery Into Practice

Research supports the possibility of recovery from schizophrenia and other psychotic disorders, yet the traditional view of these as illnesses marked by deterioration remains the most prevalent view among providers. Accepting attitudes and utilization of recovery principles are critical, but they only compose part of the necessary transformation for mental health systems to become recovery focused. It must be accompanied by policy change and the development of an entirely new conceptualization about the mental health service system and its relationship to consumers.

So, if, as evolving federal and state policy statements suggest, recovery should be the primary focus of mental health systems and key outcome for consumers, then the workforce must be adequately prepared to implement recovery principles and ideas. Several promising resources now exist to help consumers, family members, and mental health professionals learn about recovery and to promote its use in the provision of support for persons diagnosed with psychiatric disabilities. For example, the Recovery Education Center in Arizona (www.metaservices.com/rec.htm) offers workshops and training in the use of recovery principles. Boston University's Center for Psychiatric Rehabilitation (www.bu.edu/cpr) provides research, training, and service support around recovery issues.

Nevertheless, some frontline practitioners may still regard recovery as a passing fad with little utility for daily practice, or as an overly idealistic notion. The benefits of providing services from a recovery-oriented system need to be better conveyed to those working with mental health consumers: Information that is empirical, specific, and practical in application. Without addressing the underlying attitudes of practitioners, it is likely that efforts to transform services to a recovery orientation and focus will be unsuccessful. If the practitioner does not communicate hope and truly believe that recovery is possible, the client will likely not believe it either.

Excerpted from "Professional Differences in Attitudes Toward and Utilization of Psychiatric Recovery" by Eric R. Hardiman & John Q. Hodges. *Families in Society* © 2008.

A Solution-Focused Approach in Case Management

Recovery & Severe Mental Illness (SMI)

The accumulation of research shows that persons with a severe mental illness (SMI) are capable of successfully engaging in the process of recovering from their disability. No longer are consumers of mental health services viewed as passive recipients of services who are incapable of growth and change. Rather, many individuals with a severe mental disability not only are able to stay out of the hospital but also progressively improve over time in their functioning and ability to maintain themselves in the community while still having symptoms; such improvement is called *recovery*.

Traditionally, the primary job of the case manager has been to help keep consumers out of institutions and maintain them in the community. However, with the advent of mental health recovery, the focus of case management is shifting. To support consumer recovery, mental health systems and providers are asking case managers to practice in a way that focuses on increasing consumer personal growth, development, hopefulness, empowerment, and skills for coping and recovering rather than for maintenance. Case managers focusing on, identifying, and amplifying consumer strengths have been viewed as very helpful in facilitating mental health recovery. The strengths perspective can provide a general structure to the case management process. However, specific techniques and tools for consistently operationalizing this perspective on an interactional, conversational level are still under-developed. Case managers may find it very difficult to consistently maintain a focus on consumers' strengths when these consumers have many complex and long-standing problems and the mental health practice environment in which they work places great emphasis on consumers' deficits and diagnosis. It is very likely that having a more specific and coherent approach to operationalizing the strengths perspective at this level will help to counter these negative influences.

Case managers can use the interviewing and intervention tools of solution-focused therapy to further operationalize strengths-based case management. Solution-focused therapy provides conversational tools and techniques that case managers can use in patiently, consistently, coherently, and respectfully working with consumers who struggle every day with the complex challenges presented by having a severe mental disability. Case managers can consistently use solution-focused interviewing techniques to help consumers notice and use their personal strengths toward solving problems and achieving goals and, thus, increase their level of functioning. In addition, the use of these interviewing techniques should be a catalyst for increasing consumers' experience of the core common factors in recovery: hope, empowerment, coping skills, and supportive social networks.

To be effective this solution-focused approach to case management must be competently implemented; if case managers use the solution-focused interviewing tools in an inauthentic, formulaic manner, this approach could interfere with the development and maintenance of a positive, collaborative working relationship with consumers. The interviewing tools of solution-focused therapy are simple, but not simple to use effectively. Learning how to consistently use these interviewing tools in a genuine conversational style takes training, supervision, and experience. However, once case managers develop competence in solution-focused interviewing skills, they can consistently use and integrate them not only with the strengths model of case management but also with other existing case management models to enhance the recovery process of persons with a severe mental disability.

Excerpted from "A Solution-Focused Approach to Case Management and Recovery With Consumers Who Have a Severe Mental Disability Model" by Gilbert J. Greene, et al. *Families in Society* © 2006.

Learn more **online** about the **practice methods** discussed in this article:

⇨ **solution-focused interviewing**
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⇨ **core factors in recovery**

Working With Children Who Have Biologically Based Mental Disorders

Social workers have always provided services for children or youth with serious mental illness (SMI) and their families. We have not, however, always included neuroscience findings as part of our treatment frameworks. Nor have we maximized the incorporation of biological theories into our daily practice. The social work role is often unclear when mental illness is framed as a brain disease rather than solely as a social-environmental problem.

Approximately 6% of America's children and adolescents suffer with severe mental disorders, according to the National Institute of Mental Health. Another 4 million children under age 18 experience maladjustments and would benefit from mental health services. Severe mental illnesses in children are often referred to as neuropsychiatric, neurodevelopmental, or neurobiological. They include, among other things: schizophrenia, mood disorders, pervasive developmental disorders, attention-deficit hyperactivity disorder, panic attacks, and obsessive–compulsive disorder.

A bioecological approach provides a meaningful framework for assessing and intervening with children who have neuropsychiatric disorders and their families. Team assessments, diagnoses, and treatment planning is a hallmark of this treatment paradigm. As a result, the social worker's clinical roles, responsibilities, and practice methods are more clearly defined, organized, and institutionally sanctioned. Furthermore, a bioecological model frees social workers from the expectation of "curing" serious mental illness through talk therapies, and allows clinicians to focus on methods and research for improving service delivery, quality of life, and rehabilitation treatments.

Assessment and the Bioecological Model

Once a neuropsychiatric illness is manifested, biological, environmental, and interpersonal structures become major considerations for the client's treatment and rehabilitation. Unlike ecological models used in other social work practice settings, the bioecological treatment framework immediately focuses simultaneously on attending to the child's medical and environmental treatment needs. Medication is not always needed or prescribed. Nonetheless, a bioecological perspective calls for social workers to ensure that the child quickly receives complete physical, hearing, and eye exams, and medication assessment by a qualified psychiatrist and other medical experts. Furthermore, social workers are often responsible for evaluating how a child's behaviors, strengths, symptoms, and social systems are influenced by complex ecological interactions.

The assessment normally focuses on the following five ecological domains: (a) beliefs, goals, and values formed by culture, knowledge, and experience; (b) perceived and defined variance within and across environments; (c) setting's climate or personality; (d) historical and immediate interpersonal transactions; and (e) distribution, direction, and force of power generated by micro, meso, and macro systems.

Excerpted from "Practice Methods for Working With Children Who Have Biologically Based Mental Disorders: A Bioecological Model" by Edward Taylor. *Families in Society* © 2003.

Ecological Interventions

Bioecological clinicians believe that most psychiatric symptoms are directly related to brain abnormalities. Therefore, interventions most often address a child's medication, safety, and survival needs before starting psychotherapy, social skills training, or other social treatments. Not all children require medications. This is particularly true when the disorder causes only mild symptoms. Children who have severe symptoms however, require psychotropic medication treatment, along with appropriate environmental and psychotherapy support. Yet, there are also situations when medications may have only a marginal effect until major environmental changes and supports are arranged. Children who have severe neurobiological disorders and live in chaotic, traumatic, abusive, or highly neglectful homes may experience only limited relief from medications alone. These families require help from both community mental health workers and the local child protective agency. Disorganized multi-problem parents with mentally ill children are excellent candidates for family preservation services. Intensive case management, differential parent education, concrete support, and meaningful relationships guided by family preservation workers can often stabilize disruptive family environments. When these efforts do not work or are not available, the child may benefit from alternative living situations such as foster or kinship care, group homes, or residential treatment centers.

Read more about **psychiatric work** with **children and adolescents**

The Prevention of Mental Disorders in Children and Adolescents: Future Research and Public-Policy Recommendations
by Catherine N. Dulmus & Lisa A. Rapp-Paglicci. *Families in Society* © 2000

Informing Best Practices for Children in Psychiatric Crises: Perspectives and Insights From Families
by Uta M. Walter, Christopher G. Petr, & Sharah Davis. *Families in Society* © 2006

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