

INFORMATION TO USERS

This was produced from a copy of a document sent to us for microfilming. While the most advanced technological means to photograph and reproduce this document have been used, the quality is heavily dependent upon the quality of the material submitted.

The following explanation of techniques is provided to help you understand markings or notations which may appear on this reproduction.

- 1. The sign or "target" for pages apparently lacking from the document photographed is "Missing Page(s)". If it was possible to obtain the missing page(s) or section, they are spliced into the film along with adjacent pages. This may have necessitated cutting through an image and duplicating adjacent pages to assure you of complete continuity.**
- 2. When an image on the film is obliterated with a round black mark it is an indication that the film inspector noticed either blurred copy because of movement during exposure, or duplicate copy. Unless we meant to delete copyrighted materials that should not have been filmed, you will find a good image of the page in the adjacent frame.**
- 3. When a map, drawing or chart, etc., is part of the material being photographed the photographer has followed a definite method in "sectioning" the material. It is customary to begin filming at the upper left hand corner of a large sheet and to continue from left to right in equal sections with small overlaps. If necessary, sectioning is continued again—beginning below the first row and continuing on until complete.**
- 4. For any illustrations that cannot be reproduced satisfactorily by xerography, photographic prints can be purchased at additional cost and tipped into your xerographic copy. Requests can be made to our Dissertations Customer Services Department.**
- 5. Some pages in any document may have indistinct print. In all cases we have filmed the best available copy.**

**University
Microfilms
International**

300 N. ZEEB ROAD, ANN ARBOR, MI 48106
18 BEDFORD ROW, LONDON WC1R 4EJ, ENGLAND

7913145

LANDSBERG, GERALD
IMPACTING ON THE IMPLEMENTATION PROCESS AS
RELATES TO THE PROGRAM EVALUATION
REQUIREMENTS FOR COMMUNITY MENTAL HEALTH
CENTERS.

CITY UNIVERSITY OF NEW YORK, D.S.W., 1979

University
Microfilms
International 300 N. ZEEB ROAD, ANN ARBOR, MI 48106

© 1979

GERALD LANDSBERG

ALL RIGHTS RESERVED

IMPACTING ON THE IMPLEMENTATION PROCESS
AS RELATES TO THE PROGRAM EVALUATION
REQUIREMENTS FOR COMMUNITY MENTAL
HEALTH CENTERS

by

GERALD LANDSBERG

A dissertation submitted to the Graduate
Faculty in Social Work in partial fulfillment
of the requirements for the degree of Doctor of
Social Work, The City University of New York.

1979

This manuscript has been read and accepted for the Graduate Faculty in Social Work in satisfaction of the dissertation requirement for the degree of Doctor of Social Work.

2 Jan 1979
date

Irving Weissman
Chairman of Examining Committee

2 January 1979
date

Charles Gyzette
Executive Officer

Ernest P. Moran
Mark Tarnoff
Supervisory Committee

The City University of New York

ABSTRACT

Impacting on the Implementation Process
as Relates to the Program Evaluation
Requirements for Community Mental
Health Centers

by

Gerald Landsberg

Advisor: Dr. Irving Weisman

This dissertation represents a comprehensive description and evaluation of a project that was designed to impact on the implementation processes associated with the program evaluation requirements for Community Mental Health Centers mandated under Public Law 94-63 (July 1975). The paper describes the newly emerging field of policy implementation and, through a review of the literature, defines the field and delineates the processes associated with policy implementation. Through this process of delineation, the author reviews models of implementation as developed by Rein and Rabinovitz and Van Meter and Van Horn and develops the theoretical base for project activities. The specific requirements for program evaluation for CMHC's, the history of the legislation, and the role and functions of important "actors"--The National Institute of Mental Health, the regional offices of the Alcohol, Drug Abuse and Mental Health Administration, the National Council of Community Mental Health Centers and the Council on Research and Evaluation are detailed together with a delineation of the implications for project activities. Utilizing the literature from social work and organizational development, process and task goals for the project

are defined and intervention strategies outlined. Project activities are then described, along with a unique and systematic evaluation process that utilized multiple approaches. Evaluation data is presented and interpretations suggested. The paper concludes by offering comprehensive suggestions and principles for implementing and evaluating a project designed to impact on the policy implementation process.

ACKNOWLEDGEMENTS

It is with a great degree of excitement that I complete this dissertation. In the process of completing this requirement for the degree, I wish to acknowledge the substantial assistance I received from a number of individuals.

The members of my committee provided great assistance. Dr. Irving Weisman provided patience and encouragement in the process of designing and writing the dissertation. Dr. Eugene Shin, through his perceptive and informative suggestions, helped shape the research and evaluation and gave vital direction that strengthened the relevance of the study. Dr. Mark Tarail offered key insights into the nature of political processes which aided me in designing and implementing the project.

I would also especially like to acknowledge the contribution of Dr. Charles Cuezetta. It was from Dr. Cuezetta's class lectures that I received the inspiration for the project.

Myron Hulse deserves a special acknowledgement for his support in helping me through the "ropes."

I would also like to acknowledge the assistance and patience of the members of the Council on Research & Evaluation of the National Council of Community Mental Health Centers and the staff of the National Council. Their support was immeasurable.

Finally, I would like to acknowledge the firm support that my wife, Claire, provided throughout this process and the aid of my secretary, Barbara Pultz, who had the unavoidable task of translating and typing my notes into a finished product.

TABLE OF CONTENTS

Chapter

- I. INTRODUCTION 1
 - Social Experimentation
 - Policy Implementation and Social Work
 - Focusing on Impacting on the Program Evaluation
 - Requirements for Community Mental Health Centers
 - Outline of Paper
- II. THE POLICY IMPLEMENTATION PROCESS. 6
 - General Introduction
 - Delineating the Process of Implementation
 - The Role of Interest Groups In The Implementation Process
 - The Relationship of the Implementation Process to this Project
- III. BACKGROUND 14
 - Mandating Program Evaluation in Community Mental Health Centers
 - National Institute of Mental Health
 - Alcohol, Drug Abuse and Mental Health Administration Regional Offices
 - National Council of Community Mental Health Centers
 - The Council on Research and Evaluation
- IV. PROGRAM DEVELOPMENT. 56
 - The Opportunity for Action
 - Analyzing the Problem
 - Developing Strategies and Goals for Action
 - The Intermediate Goals: Task and Strategies for the Project
 - Intended Operational Activities and Timetable
- V. DESCRIPTION OF ACTIVITIES. 79
 - Process Activities
 - Task Activities
- VI. EVALUATION 93
 - An Overview
 - Results of the Evaluation

VII. CONCLUSIONS 130

 Summary of Evaluation Results
 Importance of Project
 New Knowledge or Ideas Emerging from
 the Project
 General Implications

APPENDICES. 145

 A
 B
 C

BIBLIOGRAPHY. 154

LIST OF TABLES

Table No.

- 1. Time Spent By Month 96
- 2. Time Spent By Source of Interaction 97
- 3. Achievement-Unweighted Scale.120
- 4. Unweighted Scale-Degree of Achievement Survey123
- 5. Project Goal Attainment-Weighted Scale.124
- 6. Weighted Scale-Degree of Achievement Survey126
- 7. Process Goal Attainment128

LIST OF FIGURES

Figure No.

1. National Institute of Mental Health-Organizational Structure.	22
2. Divisions and Branches of the National Institute of Mental Health Relevant to CMHC Program Evaluation. . .	23
3. National Council of Community Mental Health Centers-Organizational Structure	39
4. Project Hours By Month	100
5. Time Spent By Category of Interaction.	101
6. Time Spent By Interaction Category By Month.	102
7. Time Spent By Interaction Category By Month (Per Cents).103	

CHAPTER I

INTRODUCTION

Social Experimentation

Social experimentation, especially in new and emerging fields, is essential to the growth of a profession. Campbell underscores the value of social experimentation by noting:

there is excellent reason to believe that unless, we, as social scientists, do get into experimenting, we are never going to have a science...What I would like to emphasize is the need for experimental research in which one goes ahead and makes changes, using his own wisdom as what needs to be done, but does it in such a way that he learns whether or not he has made a difference.¹

The project, which is described in this paper, represented a social experiment that was specifically designed to (a) test the applicability of models within the emerging field of policy implementation to actual events related to mandated requirements for Community Mental Health Centers (CMHC's) in program evaluation; (b) test the utility of important principles within the social work and organizational development literature to a program aimed at impacting on the policy implementation process; (c) to develop new approaches for evaluating the impact of a program effecting policy; and, if possible, (d) to demonstrate to the field of social work the importance of the policy implementation process and the need to develop projects to impact on this process; and (e) to delineate key principles for utilization in this type of program development. Thus, the project was structured with the following intent:

research could track processes of program administration, explicate problems, as well as invent prescription...Such

inquiry and intervention of prescriptions would be of value for both policy development and program administration.²

Thus, it could serve as an important social experiment for social work.

Policy Implementation and Social Work

Policy implementation is a new and emerging field of study. It is a field that is of substantial importance, especially for social work.

Policy implementation is defined by Hargrove as:

the means by which government carries out programs on those processes of program administration which take place after a given policy has been agreed upon in a prior policy formation and decision stage.³

and by Van Meter and Van Horn as:

encompassing those actions by public or private individuals or groups that affect the achievement of objectives set forth in prior policy decisions.⁴

and finally by Pressman and Wildavsky as:

that part of a public program following the initial setting of goals, securing of agreement and commitment of funds.⁵

The importance of the implementation phase is that it ultimately shapes the direction or outcome of a proclaimed policy. This importance is noted by several observers. Ingram writes:

Policy performance frequently falls short of promise. In one major policy area after another...the bold innovative goals actualized in the legislation elude achievement.⁶

Levine suggests:

the trouble with fulfillment of the goals of social policy resulted not so much from the nature of the programs as from the difficulties of implementation.⁷

And finally Williams concludes:

The greatest difficulty in delivering better social programs is not in determining what appear to be reasonable policies on paper but in finding the means of converting these policies into field operations.⁸

Policy implementation is of special significance to social work since it

is concerned with the development of programs designed to alleviate the suffering of individuals and groups. Given these goals, social work is highly dependent on government actions and, ultimately, the implementation processes.

Despite the significance of this field to the profession, social work has demonstrated little or no interest in policy implementation. Thus, as was noted, one object of this project was to demonstrate to social work the value of this emerging field.

Focusing on Impacting on the Program
Evaluation Requirements for Community
Mental Health Centers

The focus of the project grew out of the author's involvement with the Council on Research and Evaluation of the National Council of Community Mental Health Centers. Its specific goal was to influence the implementation phase of the 1975 legislatively mandated program evaluation requirements for Community Mental Health Centers (CMHC's).

In July 1975, the Congress of the United States passed Public Law 94-63. Title III of this law, known as the Community Mental Health Center Act, contained a new and extensive series of program evaluation requirements for CMHC's. This law, and the ensuing regulations and guidelines prepared by the National Institute of Mental Health (NIMH), created a potentially important new policy. It also created numerous issues and concerns as relates to implementation and the opportunity for action to shape and mold the policy. Ultimately, the new directive created the opportunity to influence, in part, the community mental health center movement in the United States.

Thus, in essence, the project was designed to (1) impact on the evaluation requirement and, to a limited degree, the CMHC movement and, as was noted previously, (2) to serve as a demonstration project in

indicating to social work the potential of programs geared at impacting on policy implementation and in developing new knowledge on this subject.

Outline of Paper

The project, described in these pages, represents the student's activities as relates to planning, initiating, and operationalizing a social experiment. In the pages that follow, the total project is described in detail: the newly emerging concept of implementation and its relation to the project is discussed; the background facts as to the inclusion of program evaluation requirements for CMHC's in Public Law 94-63 and the development of the Guidelines are noted; detailed descriptions of the key "actors" in relation to the project and policy formulation on this issue--the National Institute of Mental Health-Central Office, the Alcohol, Drug Abuse and Mental Health Administration Regional Offices, the National Council of Community Mental Health Centers and the Council on Research and Evaluation of the National Council of Community Mental Health Centers--are included; the development of a program including descriptions of policy analysis activities, the establishment of goals and strategies (task and process) based upon the literature of social group work and organizational development and the planned steps and timetable are provided; a detailed account of program activities is included; the research design is described together with the results of the evaluation process; and finally, the report discusses new knowledge drawn from the project and the implications for social work.

CHAPTER I

FOOTNOTES

¹ Donald T. Campbell, "Administrative Experimentation, Institutional Records and Nonreactive Measures" in William Evan, (Ed.), Organizational Experiments-Laboratory and Field Research. (New York: Harper and Row, 1971), p. 372.

² Edwin C. Hargrove, The Missing Link: The Study of Implementation of Social Policy. (Washington, D.C.: The Urban Institute, 1975), p. 106.

³ ibid., p. 1.

⁴ Donald Van Meter and Carl Van Horn, "The Policy Implementation Process: A Conceptual Framework," Administration & Society. Vol. 6, No. 4, February 1975, p. 447.

⁵ Jeffrey Pressman and Aaron Wildavsky, Implementation. (Berkeley, Cal.: University of California Press, 1973), p. xii.

⁶ Helen Ingram, "Policy Implementation Through Bargaining: The Input of Federal Grants In Aid," (mimeo), University of Arizona, Department of Government, 1975, p. 1.

⁷ Robert Levine, Public Planning. (New York: Basic Books, 1972), p. 24.

⁸ Walter Williams, "Introduction," in Walter Williams and Richard Elmore, (Eds.), Social Program Implementation. (New York: Academic Press, 1976), p. 4.

CHAPTER 11

THE POLICY IMPLEMENTATION PROCESS

General Introduction

It is becoming increasingly clear to legislators, managers, program developers, evaluators and academic scholars that our notions of policy and program development have been far too circumscribed and simplistic and have failed to account for the following observations:

Policy performance frequently falls short of promise. In one major policy area after another, including civil rights, poverty and the environment, the bold, innovative goals articulated in the legislation elude achievement.¹

The greatest difficulty in delivering better social programs is not in determining what appear to be reasonable policies on paper, but in finding the means for converting these policies into operational field operations.²

The evidence from the past fifteen years is unmistakably clear. The bold promises and policy statements incorporated into legislation have often not borne fruition. Based upon this fact, the fields of political science and policy analysis have increasingly turned their attention to the process of translating policy into program activity. This process, known as implementation, is described in the following terms:

the means by which government carries out programs on those processes of program administration which take place after a given policy has been agreed upon in a prior policy formation and decision stage.³

that part of a public program following the initial setting of goals, securing of agreement and commitment of funds.⁴

encompasses those acts by public and private individuals or groups that affect the achievement of objectives set for them in prior policy decisions.⁵

at issue is the universal problem of putting a decision into effect. All of us know that deciding to quit smoking or to lose weight, sad to say, is only the first step toward a solution. In a complex organization, such as a government agency, the same mundane distinction between a decision and its implementation pertains, although many parties may be involved in the decision and the process of implementation, may move through several hierarchical layers.⁶

Despite the fact that implementation is, as we noted, a crucial determinant in effecting the outcome of policy, it is an area that has not been subjected to intense investigation. Williams described this lack as follows:

We simply do not know how to implement new social programs or major program modifications. This is not surprising because implementation is an exceedingly difficult task. What is so hard to fathom is why so little has been done to investigate the process of implementation since that activity is of crucial importance in program operations, policy analysis and evaluative research, particularly social experimentation.⁷

Delineating the Process of Implementation

Based upon the limited but growing work in this field, consisting both of theoretical works and a few case studies, it is possible to delineate some of the steps and factors involved in the implementation process.

Rein and Rabinovitz define the general process as follows:

a declaration of government preferences, dictated by a number of actors who create a circular process characterized by reciprocal power relations and negotiations.⁸

Specifically, these authors suggest that the process involves four steps, (1) legislation, (2) guideline development, (3) resource distribution, and (4) oversight.⁹

Rein and Rabinovitz define these steps and their importance as follows:

(1) Legislation: "The law itself becomes the referent for all the actors in the process..."¹⁰ They also note that factors associated with the legislation and the process of its becoming law, effect the process of implementation. Among the items cited are the expertise of the committee drafting

the law, the clarity of language in the law, the extent to which disagreements about the law are clarified and level of support for the law.¹¹ (2)

Guideline development is the first stage in the process of implementation following the legislation. It is normally the responsibility of an administrative agency. In the guidelines, "legislative intent is translated into administrative prescriptions for action."¹² In this translation process, the bureaucracy's power is actually enormous. They note:

These guidelines are more than a mere reinterpretation of the legislation. Buried in guidelines are numerous decisions about how to make a program work. For example, an agency must decide whether it should prescribe specific requirements or simply indicate the type of result it favors.¹³

They further indicate: "Once developed, guidelines are promulgated to those individuals in departments who must ultimately administer the program. In the case of federal legislation, the new regulations and their guidelines are published in the Federal Register, and these are often modified after interested parties get a chance to challenge them."¹⁴ (3) Resource Distribution: The next stage in the process involves resources - the amount, their distribution and the timing of the release of funds. Key questions include: How much money is allocated to the administrative agency? When does the money come to the agency? And for what activities does the agency spend the funds?¹⁵ (4) The Oversight Process: Oversight processes are started "as a way of promoting accountability at the lower levels of the bureaucracy"¹⁶ and attempting to insure some level of compliance by grantees. It is based upon the concept that noncompliance threatens democratic principles: "If guideline evasion is rampant, the legitimacy of the legislation is threatened. The commonly used focus of oversight are monitoring, auditing and evaluation. Monitoring is concerned with whether practice complies with guidelines."¹⁷ Auditing involves the monitoring of financial accounts. Evaluation is concerned with whether practice

produces results.

This framework provides important conceptual information. Additional perspectives are provided by a model developed by Van Meter and Van Horn.

In the Van Meter and Van Horn model, a number of important factors are:

Resource concerns, which include financial and other resources available for implementation (including administration and enforcement) and the process of allocation of resources.

Standards, which are found in the legislations, regulations, guidelines, statements by policy makers, news releases and procedures. The value of these standards are:

These policy statements tell Federal, State and local implementors what is expected of them and indicate the amount of discretion left open to them. Policy standards also provide overseers with tools of inference and enforcement since they set limits in the types of activities that are tolerable and on the sanctions that can be imposed for deviations.¹⁸

Communications are significant in that:

Policy standards cannot be complied with unless they are communicated with sufficient clarity so that implementors will know what is required of them.¹⁹

Enforcement is not a simple task. The most extreme form of enforcement, that which involves the cutting off of funds, is rarely employed due to possible harmful consequences, e.g.-embarrassment to the Federal government, damage to an ally, generating Congressional hostility. Instead, other forms of enforcement are usually employed. These forms include: incentives - money, technical assistance, research and staff aid; co-optation and persuasion - through socialization activities; and coercive acts - elaborate reporting and accounting systems, site visits, program reviews and evaluation.²⁰

Disposition of implementors towards policy is an essential factor. The implementation of a policy depends upon the degree of support for the policy and at what levels the support exists in the agency.²¹

Characteristics of the implementing agency effect the implementing process. The primary organizational characteristics of the implementing agency(ies), e.g. it's status, whether it is an independent body or a part of a larger organization, and the degree of centralization or decentralization, are important factors.²²

The Role of Interest Groups in the Implementation Process

Of particular importance to this paper is the role of interest groups in the implementation process. As was suggested earlier, interest groups play a key and significant role in the implementation process. Rein and Rabinovitz note "that the implementation phase of the political process is where policies can be modified to suit individual or group interest."²³ The attitudes and preferences of these groups effect regulations, guidelines and resource distribution. These authors cite two illustrations to underline the influence of interest groups:

When an agency owes it's existence to outside interest...it has to pay substantial attention to these groups. For example, the origin of environmental policy as well as it's administration through the Environment Protection Agency (EPA) developed out of the very political movement that made environmental quality a public issue. The agency, as a result, faced activist, informed, educated constituences accounted for it's very being. Therefore, any opposition to the regulations that exist has come from outside interests attached to oil and energy industries which are in competition with the EPA.

...Consider the case of regulating the radiation from power plants. About 1971, at a time when the environmental lobby enjoyed a position of maximum influence and power, the authority to set standards was assigned to the Environment Protection Agency. The agency, in turn, set strict standards for individual plants and tried to intervene at each step in the radiation cycle in order to ensure that nuclear power plants were guarding against the potential dangers of radiation. When the energy crisis later shifted the source of power to the producers of energy, the Nixon Administration, without a change in legislation, reassigned the responsibility for radiation control to the Atomic Energy Commission, which presumably held a more relaxed attitude toward radiation procedure.²⁴

Interest groups, as was indicated, are thus, in an important position

to influence the implementation process. Their ability to effect the process is determined by their actual or perceived power, their cohesiveness, their intensity of interest in a policy and the degree to which the external party can establish a cooperative and harmonious working relationship with the government agency or bureau.²⁵

The Relationship of the Implementation Process to this Project

The essence of this project was to operationalize a limited social experiment through which the student could structure specific activities of an interest group (the National Council of Community Mental Health Centers, Inc. and the Council on Research and Evaluation) to influence the implementation acts of governmental regulators - the National Institute of Mental Health and the ten Alcohol, Drug Abuse and Mental Health Administration Regional Offices. The focus of the project was not primarily directed at the process involved in legislation or guideline development, since in terms of timing this had passed, but were rather directed at the resource allocation, oversight processing stages and at the communication and enforcement processes, and attitudes and dispositions of the implementors. The specific nature of the project and the activities involved are discussed in a latter section.

CHAPTER II

FOOTNOTES

¹Helen Ingram, "Policy Implementation Through Bargaining: The Input of Federal Grants in Aid," (mimeo), University of Arizona, Department of Government, 1975, p. 1.

²Walter Williams, "Implementation Problems in Federally Funded Programs" in Walter Williams and Richard Elmore, (Eds.), Social Program Implementation. (New York: Academic Press, 1976), p. 4.

³Edwin C. Hargrove, The Missing Link: The Study of Social Policy. (Washington, D.C.: The Urban Institute, 1975), p. 1.

⁴Jeffrey Pressman and Aaron Wildavsky, Implementation. (Berkeley, Cal.: University of California Press, 1973), p. xii.

⁵Donald Van Meter and Carl Van Horn, "The Policy Implementation Process: A Conceptual Framework," Administration & Society. Vol. 6, No. 4, February 1975, p. 447.

⁶Williams, op.cit., p. 3.

⁷Ibid., p. 3 and 4.

⁸Martin Rein and Francine F. Rabinovitz, Implementation: A Theoretical Perspective. (Cambridge, Mass.: Joint Center for Urban Studies of MIT and Harvard University, 1977), p. 8.

⁹Ibid., p. 8 and 17.

¹⁰Ibid., p. 9.

¹¹Ibid., p. 10

¹²Ibid., p. 17.

¹³Ibid., p. 19

¹⁴Ibid., p. 17.

¹⁵Ibid., p. 22.

¹⁶Ibid., p. 17.

¹⁷Ibid., p. 17.

¹⁸D. Van Meter and C. Van Horn, op.cit., p. 464.

¹⁹Ibid., p. 466.

²⁰ ibid., p. 465.

²¹ ibid., p. 466.

²² ibid., p. 466.

²³ M. Rein and F. Rabinovitz, op.cit., p. 6.

²⁴ ibid., p. 13 and 14.

²⁵ D. Van Meter and C. Van Horn, op.cit., p. 464.

CHAPTER III

BACKGROUND

Mandating Program Evaluation in Community Mental Health Centers

Background

Program evaluation requirements for community mental health centers are a new phenomenon. For the first ten years of the CMHC program, (1965-1975), program evaluation was not required of centers. It was not until the passage of Public Law 94-63 (Title III of which is entitled "The Community Mental Health Center Amendments") in July 1975 was there a legislative mandate of evaluation.

The lack of mandatory evaluative activities can probably be traced to numerous factors, e.g. newness of program, lack of manpower, but also to the lack of NIMH interest. Chu and Trotter, in a study conducted by the Ralph Nader sponsored-Center for Responsive Law, write:

Perhaps the fundamental reason that NIMH did not begin evaluation efforts on it's own initiative is that evaluation does not serve the Institute's bureaucratic self interests.¹

These authors suggest that NIMH's motivation lay in the expansion of the CMHC program and that other activities were seen as either secondary or detrimental to that goal.²

A number of general trends, together with specific events, led to a change in direction in relation to evaluation. By the early 1970's, increasing attention was being focused on the cost and on the effectiveness of health and mental health programs. In contrast to the atmosphere

surrounding the events of the mid 60's with it's enactment of heralded social programs, e.g. Medicare, Medicaid, the war on poverty, the 70's marked a period of cost consciousness and skepticism. The question: How much worth are we getting for our buck? became commonplace. This question was often translated into legislative or regulatory requirements for social programs to demonstrate their effectiveness.

In addition to this general trend, the lack of program evaluation in CMHC's was noted and heavily criticized in two widely read reports issued by influential organizations. The Ralph Nader sponsored Center for the Study of Responsive Law issued, in the latter part of 1972, a report on CMHC's. This report heavily criticized the failure to implement CMHC programs that met the stated goals and scored the lack of evaluation in centers. In it's criticism, the report took both NIMH and Centers to task for this lack. The report concluded with a series of recommendations, among which was the following suggestion:

Each Center should be required to establish an ongoing program of evaluation stating not only if the yearly goals specified are reached, but also all possible aspects of the Center's operation (including a quality of care, administrative efficiency, etc.) ...Results of this ongoing evaluation should be published yearly and distributed to the Community.³

The Nader study was shortly followed by a report by the U.S. Comptroller General - General Accounting Office on the CMHC program. (August 1974) This report strongly criticized CMHC's for the lack of adequate management, both programmatic and financial, and the failure to develop program evaluation activities. The GAO report also strongly stressed the need to improve performance in these areas.⁴

Congress, through the forementioned studies and other input, became aware of the need to change the CMHC program.

Public Law 94-63 Title III-The Community Mental Health Center Amendments

The vehicle which became a major source of change as relates to CMHC's requirements in the areas of clinical, consultation and administrative services was Public Law 94-63 Title III of which is known as the Community Mental Health Center's Act. Public Law 94-63 became the "law of land" in July 1975 after it was passed over Presidential veto. The Community Mental Health Center amendment mandated program evaluation activities in uncharacteristic (for this type of legislation) detail. For Centers receiving funds under PL94-63, the law specified the following requirement:

...an effective procedure for developing, compiling, evaluating and reporting to the Secretary (HEW) statistics and other information (which the Secretary shall publish and disseminate on a periodic basis and which the center shall disclose at least annually to the general public) relating to (a) the cost of the Center's operation (b) the patterns of use of it's services (c) the availability, accessibility and acceptability of it's services (d) the impact of it's services upon the mental health of the resident of it's catchment area...

...such community mental health center will, in consultation with the resident of it's catchment area, review it's program of services, and the statistics and other information referred to (above).

...In each fiscal year for which a community mental health center receives a grant..., such a center shall devote, for a program of continuing evaluation of the effectiveness of it's program in serving the needs of the residents of it's catchment area and for a review of the quality of the services provided by the Center, not less than an amount equal to 2 per centum of the amount obligated by the center in the preceding fiscal year for it's operating expenses.

...A center shall have established in accordance with the regulation prescribed by the Secretary...an ongoing quality assurance program (including utilization and peer review systems) respecting the Center's services.⁵

The law also mandated a role for the National Institute of Mental Health in helping Center's improve their management and evaluation capabilities. The legislation mandated that NIMH was to provide technical assistance to Center's on management issues including evaluation. The

law stated:

Not more than 2 per centum of the total amount appropriated under (CMHC budget amount) for any fiscal year shall be used by the Secretary to provide, directly through the Department, technical assistance for program management and for training in program management to community mental health centers.⁶

Guidelines for Program Evaluation

The enactment of legislation is but the initial step in the process of translating law into actions. The translation of the program evaluation mandates of Public Law 94-63 into action required the NIMH develop guidelines. The guidelines operationally define the law into specific tasks which are required of grantees to comply with Federal standards. Guidelines also serve as tools for education and accountability for grantees and the granting agency. Davis, Windle and Sharfstein, in discussing the CMHC Program Evaluation Guidelines, define that function as follows:

The value of guidelines is determined by their appropriateness. Guidelines carry an inherent significance in furthering the intention of Congress in the use of Federal funds. Beyond that, they can contribute to the attainment of standards for program evaluation that should help bear beneficial fruit.⁷

The guidelines were developed over a period of two years by NIMH. During these two years, over 500 persons and organizations were consulted, including the National Council of CMHC's.⁸ The guidelines went through numerous drafts and revisions, however, even while in draft form, they were utilized as temporary standards.

The final guidelines, which have become the operation standards by which NIMH and the ADAMHA Regional Offices can measure the degree of compliance by CMHC's, contained the following specifications:

Staffing-In order to focus responsibility and facilitate communication, each center should appoint one person to coordinate evaluation efforts and reports, giving him or her means to consult with center decision-makers in planning for changes indicated as desirable on the basis of evaluations, considered with other factors. The persons who conduct the center's program evaluation... should be qualified by training and/or experience to do so effectively.⁹

Information Capability-The capability to collect and integrate data on clients, staff, funds and services delivered is basic to program evaluation although the routine operation of such information systems is not itself program evaluation...This management information system should, as a minimum, provide data for the annual statistical report, the inventory of comprehensive CMHC's, required of all operating centers. The statistics in the annual report provide a basis for center evaluation when used to assess movement toward the fulfillment of a Center's objectives and goals or other valuable criteria.¹⁰

Content Focuses

- (a) Cost of Operation-The estimate cost of the center operation... Ideally this should be calculated for episodes of direct and indirect service on the Center as a whole and for units of major types of services.
- (b) Use of Service-The numbers and rates of catchment area residents use of the Center's service, by element of service and clients age, sex, family income, race and geographic sub area.
- (c) Availability, Accessibility and Acceptability
 - (1) Availability-the amount of various types of service per 1000 catchment area residents.
 - (2) Accessibility-
 - (I) Temporal-days and hours center's are open for admission.
 - (II) Geographic accessibility.
 - (III) Financial accessibility-absence of deterrent barriers to treatment resulting from fees.
 - (IV) Psychological and
 - (V) Sociocultural accessibility-climate of acceptance, respect and understanding at the center.
 - (3) Acceptability of Services-predilection to use of service.
- (d) Impact-The impact of center services on the mental health and related problems of the residents of the catchment area, their families and friends and, to the extent that reasonable estimates are possible, their neighbors, employers, other care-giving agencies and the general public.
- (e) Other Matters-
 - (1) The center should also consider the impact of it's indirect consultation and education services in attaining program goals.

- (2) Awareness of service.
- (3) The effectiveness in reducing inappropriate institutionalization.¹¹

Citizen Review and Response

Each Center is required to plan and carry out a procedure at least annually for formal review of information derived from evaluation efforts. The formal review must be conducted in consultation with the residents of its catchment area and should involve an open, announced public forum...The center's procedures to involve catchment area residents in evaluation should include (a) publicity (b) provision of brief summaries of the evaluation report...(c) making copies of the annual evaluation report available to the public inspection and (d) recording suggestions and evaluations by catchment area residents.¹²

Annual Evaluation Report

Annually each center must prepare an evaluation report as required involving the center board to the extent the board is able, to be available as a separate document and also submitted as part of additional grant applications.¹³

These Guidelines also discuss the subject of Technical Assistance and notes:

Several efforts to assist Centers to develop useful program evaluation have been mandated by Congress in the CMHC Act and are being implemented by the NIMH and DHEW Regional Offices. Program Evaluation is among the topics for which special technical assistance support is provided. Centers should make their needs known to their Regional Office. Furthermore, mental health services research grants and 1% program evaluation contracts continue to develop evaluation methods.¹⁴

An Introduction to the "Actors"

The review of the law, guidelines and the historical development have provided us with a "framework or stage set." The review also provides some outlines as relates to the goals and tasks for the project which are discussed in the latter sections. The law and guidelines do not provide us with substantive information as to the key actors and their roles in this project (melodrama). In the following sections, the "key actors"-Central Office of the National Institute of Mental Health, the Regional ADAMHA (DHEW) Offices, the National Council of Community Mental Health Centers

(NCCMHC), and the Council on Research and Evaluation of the National Council, and their roles are explored.

National Institute of Mental Health

Background and Historical Development

The National Institute of Mental Health (NIMH) is that agency of the Federal government that has primary responsibility for developing and implementing policy in the area of mental health.

The Institute was established in 1947 as a direct result of the passage of the National Mental Health Act of 1946. Its essential tasks were defined as follows:

...to be actively involved in the areas of research, demonstration, coordination, training and assistance to states in the use of the most effective methods of prevention, diagnosis and treatment of psychiatric disorders.¹⁵

Through the period of 1947 until 1963, NIMH was concerned almost exclusively with training and research. The role of the Institute changed dramatically with the passage of the Community Mental Health Centers Act of 1963. That act designated NIMH as being responsible for the development, implementation and ongoing supervision of the CMHC program.

Present Functions

Organizationally at the present time, NIMH is one of the three divisions under the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) which is part of the Public Health Service under the umbrella of the Department of Health, Education and Welfare. The budget of NIMH is 579 million dollars of which 269 million or 46% is for funding of CMHC's, 112 million for research, 84 million for training, 7½ million for community support programs, 76 million for St. Elizabeth's Hospital and 30 million for NIMH staff functions.¹⁶ Its central headquarters are in Rockville, Maryland.

The current purpose and function of the agency is defined in its

Handbook (1977) as follows:

Provides leadership, policies, and goals for the Federal effort in the promotion of mental health, the prevention and treatment of mental illness, and the rehabilitation of affected individuals. In carrying out these responsibilities, the Institute: (1) Conducts and supports research on the biological, psychological, sociological, and epidemiological aspects of mental health and illness; (2) supports the training of professional and paraprofessional personnel in the promotion of mental health and the prevention and treatment of mental illness; (3) conducts and supports research on the development and improvement of mental health services delivery, administration, and financing and supports mental health services programs and projects including facilities construction as appropriate; (4) collaborates with and provides technical assistance to State authorities and Regional Offices, and supports State and community efforts in planning, establishing, maintaining, coordinating and evaluating more effective mental health programs; (5) collaborates with, provides assistance to, and encourages other Federal agencies, national, foreign, State and local organizations, hospitals, and volunteer groups to facilitate and extend programs to promote mental health and prevent mental illness, and for the care, treatment, and rehabilitation of mentally ill persons; (6) carries out administrative and financial management, policy development, planning and evaluation and public information functions which are required to implement such programs; (7) exercises administrative and policy oversight for the operation of Saint Elizabeth's Hospital.¹⁷

Despite the numerous responsibilities listed, NIMH's most important task, operationally and politically, is to supervise the CMHC program. Aside from the importance of the CMHC program to the overall NIMH program, the fact is that the CMHC program provides NIMH with its major vehicle for interface with legislative organizations, professionals and professional organizations and the public at large. This point needs further elaboration. NIMH's research and training efforts, although extensive, are primarily vehicles for contact with the professional and academic communities. The CMHC program, and there are approximately 650 CMHC's serving over 1/3 of the country, involves NIMH directly with the public and, as a result, with Congress, citizen's groups and organizations.

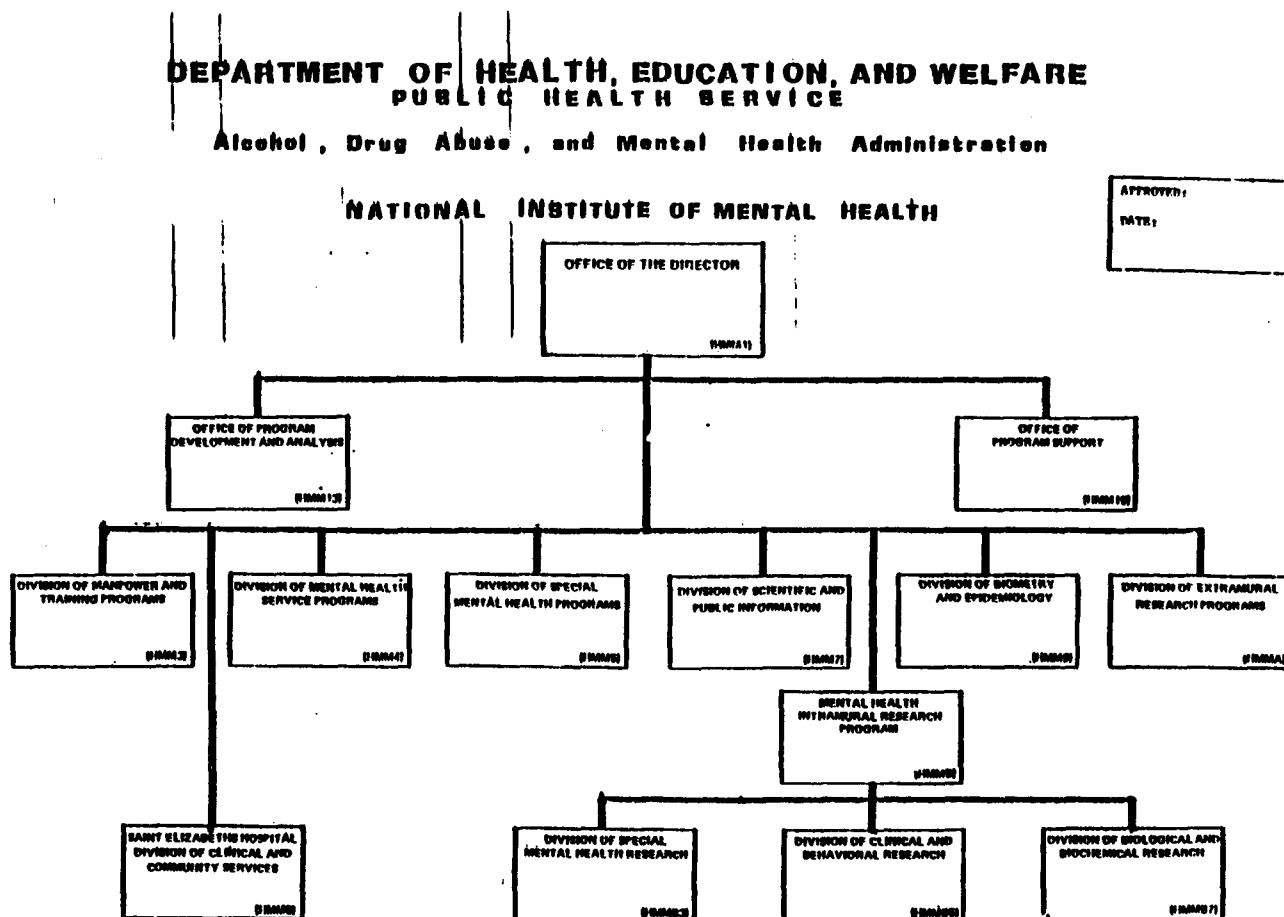
NIMH: Overall Organization

The Institute is a very complex organization with numerous divisions

and bureaus. The complexity of this structure can be seen by the organizational chart on the next page. In reviewing this chart, it is quite obvious that many of its divisions have little or no relevancy to the CMHC program or CMHC program evaluation activities. It is for that reason that they, for the purposes of this paper, will be ignored. The paper will focus on those divisions that have important responsibilities for CMHC and program evaluation.

Figure 1 describes the overall organization of the National Institute of Mental Health.

FIGURE 1

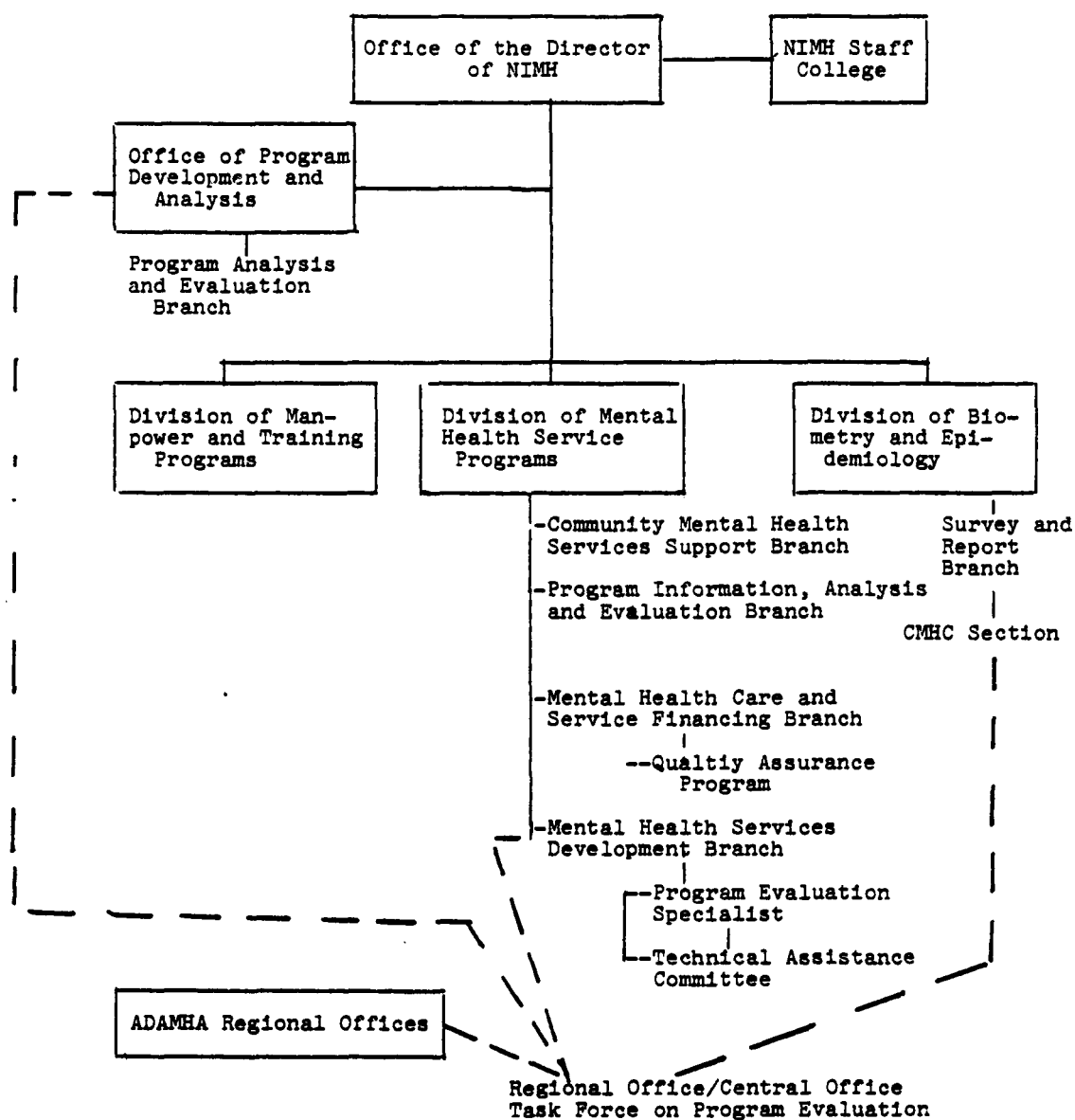


The NIMH Divisions Relevant to CMHC's and to Program Evaluation

In Figure 2 below, the key divisions and branches of NIMH that have relevance to CMHC program evaluation are identified.

FIGURE 2

DIVISIONS AND BRANCHES OF THE
NATIONAL INSTITUTE OF MENTAL HEALTH,
RELEVANT TO CMHC PROGRAM EVALUATION



Office of the Director-NIMH

The Office of the Director has the following responsibilities:

- A. provides leadership, direction and policy in the development of the Institute goals, priorities, policies and programs..., and serves as the social point for the Department's efforts in mental health and illness;
- B. provides overall program coordination;
- C. conducts and coordinates Institute interagency, intercoordination and...including liaison with Regional Offices;
- D. assesses the impact of Institute programs;
- E. provides support to the Institute in various areas of administrative management and in program development, policy analysis and legislative analysis.¹⁹

It is due to it's prominence in policy making that the Office of the Director is important. Operationally, during the last year, the Office has been unsettled. The long-term Director was, for many months, out of favor with the Secretary of HEW and finally forced to resign in January 1978. The Institute has, for the last six months, operated with a temporary Director.

Office of Program Development and Analysis

The Office of Program Development and Analysis is directly under the Director of NIMH and is part of the larger Office of Director. It's general responsibilities are as follows:

- A. develop program plans and monitors progress towards established objectives;
- B. analyzes program policy and activities and develops recommendations for critical program change;
- C. develops Institute program evaluation policy and plans and initiates proposals for, and participates in, program evaluation;
- D. develops data requirements pertinent to planning and evaluating program activities.²⁰

With this Office, the key branch is the Program Analysis and Evaluation Branch. The Branch has the following responsibilities:

- A. develops a system for analysis of the Institute's programs and prepares reports reflecting program status;
- B. develops Institute program evaluation policy and strategy for utilizing evaluation funds;
- C. coordinates the development of an annual Institute program evaluation plan which includes specifications for contract studies;

- D. monitors evaluation contracts from initiation to termination and takes action to insure that accepted evaluation study recommendations are implemented;
- E. serves as an information resource for the planning function and other Institute activities;
- F. integrates data from research programs, program analysis, program evaluation and biometric surveys and other sources for the preparation of major reports with significant policy implications.²¹

The Office of Program Development and Analysis, and especially the Program Analysis and Evaluation Branch, play a key role as relates to program evaluation. As a factor of it's location in the Office of the Director of NIMH, this group has an influential role in helping to determine NIMH policy and program evaluation activities. The Program Analysis and Evaluation Branch has a significant role in planning the issues related in CMHC services which will be studied on a national basis. It prepares Request for Proposals (RFP's) for these contracts to study priority issues. Based upon study results, it often prepares recommendations for policy action.

Division of Manpower and Training Programs

This division has the following function:

- A. plans, administers, and supports programs in the planning, development, training and utilization of mental health manpower to meet mental health service delivery system and research needs...;
- B. collects and analyzes data and conducts studies related to nationwide perspectives and needs regarding mental health manpower planning, training, development and utilization.²²

The Division includes a Psychiatry Education Branch, Psychology Education Branch, Social Work Education Branch, Psychiatric Nursing Education Branch, Mental Health Research Manpower Development Branch, Manpower and Analytic Studies Branch, and the Vestermark Center for Manpower Development.²³

The Manpower and Training Division has some importance to evaluation due to the fact it currently provides some financial support to evaluation training programs, e.g. Columbia University School of Public Health, Florida State University, University of Oregon. The present support is limited, but

it could support other projects to train mental health evaluators.

Division of Biometry and Epidemiology

The division has the following general functions:

- A. advises and assists in the development of biostatistical and other statistical analysis programs in the operating components of NIMH and the other ADAMHA Institutes, recommends policies and standards for the operation of such programs and provides statistical and mathematical services to other ADAMHA Institutes as requested;
- B. conducts research and develops quantitative models for research and data collection in the areas of biometric, epidemiologic and demographic significance;
- C. coordinates Institute activities in mental health epidemiology; develops and supports programs of research, training, field trials and demonstrations pertaining to epidemiology; and operates field stations for the conduct of epidemiology studies;
- D. carries out a national reporting program and stimulates the development of projects for the collection and analysis of data on the characteristics and patterns of use of mental health and related facilities on a national, regional, State or local level;
- E. provides technical assistance in statistical and epidemiologic methodology, development of mental health information systems and in the use of statistical, epidemiologic and demographic data in program management and research through consultation, conferences, workshops, seminars and publications.²⁴

In this Division, the key branches include the Survey and Reports Branch, the Statistical Program Development Branch, and the Center for Epidemiological Studies. The Survey and Reports Branch has the following responsibilities:

- A. conducts annual and special surveys on the characteristics of mental health and related facilities and of the patients served;
- B. develops standardized reporting procedures and definitions and carries out special studies to evaluate the reliability and feasibility of reporting techniques;
- C. analyzes data resulting from these surveys and issues reports on the findings.²⁵

One component of the Survey and Reports Branch is the Community Mental Health Centers Section which:

- A. conducts annual and special studies on the characteristics, staffing, funding, expenditures and patient populations served in Federally funded community mental health centers;

- B. Analyzes data resulting from these surveys, prepares and issues reports on these findings.²⁶

The Statistical Program Development Branch, as part of this division, has the following functions:

- A. provides advisory and consultative service to administrators of State and local mental health programs on the organization of statistical reporting systems, and on the use of statistical data and related information for program planning, evaluation and management;
- B. gives direction and guidance to the Regional Offices in the development of necessary statistical services and activities;
- C. collaborates with regional and national groups of biostatisticians to improve the level of statistical services in mental health and related programs;
- D. develops biostatistical manpower in mental health through stimulation and support of training activities.

The last key branch within this division is the Center for Epidemiologic Studies, which has the following responsibilities:

- A. serves as focal point for and coordinates Institute activities in mental health epidemiology;
- B. analyzes and evaluates current research and related program developments in this area;
- C. conducts research, and stimulates, develops, and supports programs of research, training, field trials and demonstrations pertaining to epidemiology using such means as research and training grants, contracts and conferences;
- D. operates regional field stations for surveillance of local mental health conditions and conduct of studies within their catchment areas;
- E. collaborates with organizations outside the Institute including State and local agencies to facilitate program development;
- F. stimulates communication of information through consultation and the development of conferences, committees and publications.²⁷

The Biometry and Epidemiology Division is important to program evaluation in that (a) preparation of reports for that Division constitutes an important function for CMHC evaluators; (b) the data from Biometry can be useful on ongoing program evaluation; and (c) the data can have implications for national policy in that it is the only source of detailed statistical data that provides some degree of measurement of the success or failure of the CMHC program.

Division of Mental Health Service Programs

The Division which has primary responsibility of the CMHC programs is that of Mental Health Service Programs. The division has the following functions:

- A. Plans, develops, administers, and evaluates programs for the support of mental health services nationwide, including (1) planning, operations and facilities assistance for comprehensive community mental health centers (2) improvement of the quality of care and competence of staff in State mental hospitals; and (3) general improvement of State and local systems for the delivery of mental health services;
- B. provides new knowledge of direct relevance to the delivery of mental health services through intramural research and development programs;
- C. provides technical assistance, training and consultation to regional offices, State, public and private nonprofit and voluntary agencies in program development, administration, financing and evaluation of mental health services;
- D. coordinates Institute activities and consults with other Federal and State agencies on mental health aspects of medical care provided under legislation and in agreements with other agencies;
- E. coordinates Institute activities in such special areas as community care of chronic patients, children's mental health services, citizen participation, patient rights, rural mental health and mental health aspects of the National Health Service Corps; and
- F. recommends and assesses legislative budgetary and policy initiatives related to the delivery of mental health services.²⁸

Within the Division the key branches are the Community Mental Health Service Support Branch, the Mental Health Services Development Branch, and the Mental Health Care and Services Financing Branch. The Community Mental Health Services Support Branch has the following functions:

- A. Plans, administers and evaluates programs concerned with the development and improvement of nationwide community mental health services through use of Federal grants;
- B. identifies national program goals and priorities and develops regulations and policies for program implementation;
- C. assures the collection and analysis of data relevant to the extent and effectiveness of programs supported through community mental health centers and HIP grants;
- D. provides resources and assures technical assistance to State and local governments, institutions, community groups and other Federal agencies and collaborates with such groups in stimulating the development of mental health services delivery systems;

- E. provides consultation to DHEW regional office staffs and participates with regional offices in consultation to applicants, grantees, and others on legal, regulatory, fiscal, program and management problems;
- F. consults with other NIMH components in the conduct of activities directed toward fostering and enhancing improvement in mental health service models;
- G. serves as the focal point for, and coordinates Institute activities designed to encourage participation of private citizen and voluntary citizen organizations in mental health activities;
- H. promotes demonstration and training to implement citizen involvement programs and stimulates communication of appropriate information through consultation, conferences, and publications;
- I. coordinates Institute activities in building service linkages and developing integrated community support systems which will maintain pre- and post-institutionalized individuals in the community at optimal levels of functioning;
- J. analyzes developments in Federal, State and local mental health community support programs;
- K. identifies issues and problems in the provision of appropriate community-based care and promotes policy changes, research, training and technical assistance which will overcome obstacles and improve service delivery.²⁹

The Mental Health Services Development Branch, within the larger division, has the following responsibilities:

- A. Promotes the continued improvement and development of mental health services through (1) planning, implementing, and supporting research and training projects through which new mental health service models are initiated and improvements in existing programs and practices are introduced, (2) interpreting and fostering the diffusion and adoption of knowledge derived from research and operations relative to the progressive planning and development of mental health services, (3) providing technical assistance consultation to mental health services providers to encourage and assist in the development of model programs of high quality, (4) studying, testing and implementing methods to improve the interface between technological progress and more effective services;
- B. fosters effectiveness and efficiency in specific service areas, through needs assessment, knowledge retrieval and generation, and systems operations including children's services, sheltered programs, services for the elderly, rural services, planning, evaluation, integration of services with allied systems, clinical facility programs, and organizational management;
- C. coordinates mental health services research and development with appropriate NIMH elements and other Federal programs.³⁰

It should also be noted that within the branch there are two entities

that are of crucial importance to CMHC program evaluation. (a) One is an organizational entity-The Technical Assistance Committee. Technical assistance consists of the provision of training, education and consultation to CMHC's to improve their program management. This assistance is mandated legislative (PL94-63) and requires that up to 2% of the funds allocated for CMHC services should be used for those services. This technical assistance is provided both by the NIMH Central Office and the ADAMHA Regional Offices by funds allocated under this legislative mandate. The Technical Assistance Committee coordinates all TA activity and reviews and approves funding proposals. (b) The other crucial entity consists of the Program Evaluation Specialist. More than any other individual in the Institute, this Evaluation Specialist has influenced and been concerned with the development of program evaluation in CMHC's. He has fostered this movement by helping in the development of Technical Assistance projects through his role in the Regional Office/Central Office Task Force on Program Evaluation and by direct CMHC contact. Through his writing and personal communications, the Evaluation Specialist has also fostered the dissemination of program evaluation information to CMHC's.

It should also be noted that the Mental Health Services Department Branch had the major responsibility for preparing the Guidelines on CMHC Program Evaluation.

The last branch with the division that warrants our attention is the Mental Health Care and Service Financing Branch. This branch has the following functions:

- A. Serves as the focal point for and coordinates Institute activities concerned with financing and assurance of quality mental health care under Federal health, health insurance and Social Security legislation, and activities concerned with the rights of the emotionally distressed;

- B. consults with other Federal and State agencies on the mental health aspects of medical and social services financed by or through these programs;
- C. stimulates the coverage of mental health services in public and voluntary health insurance, medical and social assistance programs;
- D. examines the relationship nationwide between fiscal resources and the organization and delivery of mental health services and evaluates the economic impact of various sources and levels of funding on these services;
- E. provides information and guidance to mental health programs nationwide regarding funding resources for mental health services, quality assurance approaches to the evaluation of mental health patient care, and patient rights;
- F. provides consultation and technical assistance to other Federal agencies and private organizations on (1) the development, policy formulation and implementation of the mental health requirements of Federal health, health insurance and Social Security programs, and (2) the assessment, improvement and development of programs, policies and procedures concerned with the maintenance and advancement of the rights (constitutional and clinical) of the emotionally distressed;
- G. promotes the development of research and training programs in mental health care administration and in financial management and patient care evaluation.³¹

This branch has its impact in the area of program evaluation as a result of its concern with the issues of peer review and quality assurance.

Both issues, although clinical in nature, are generally operationally defined as being in the area of program evaluation. Within the branch, the Chief of Quality Assurance and Standard Program is very concerned with the development of quality assurance systems in CMHC's.

Regional Office/Central Office Task Force on Program Evaluation

As we will discuss in the section on Regional Offices, these are not technically or actually part of the structure of NIMH. Regional Offices are part of the larger umbrella organization-Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). Despite this lack of connection to the formal NIMH structure, Regional Offices play a crucial role in relation to CMHC's. These Regional Offices review and approve all CMHC grant applications, monitor the function of centers and plan and implement

Technical Assistance programs for Centers. Given this organizational quirk and the fact that program evaluation responsibilities are spread across a number of Divisions and Branches within NIMH, it became necessary, in light of mandates for evaluation, to establish a coordinating mechanism. In 1975, under a charter from the Director of NIMH, a Regional Office/Central Office Task Force on Program Evaluation was established. The purpose of the Task Force was to coordinate activities on program evaluation between regions and between the regions and the Central Office. It's role also included initiating ideas for Technical Assistance projects and reviewing Technical Assistance proposals in the area of program evaluation. In fact, the functioning of the Task Force has been "spotty." It has gone through long periods of not meeting; Central Office participation has been more vigorous than Regional Office participation; and often, members were unclear as to it's specific purpose. However, it still is a potential influential group.³²

NIMH Staff College

The NIMH staff College is a recent creation and directly under the Director of NIMH. Unlike the other entities described, the Staff College has no operational responsibilities. It was established as an intramural component of the Institute to meet education needs of NIMH and ADAMHA staffs. It's programs were later expanded to be open to members of Federal, State and local mental health programs. In the course of it's activities, that Staff College has developed and implemented numerous seminars and workshops in the area of program evaluation and quality assurance.³³

Summary

The National Institute of Mental Health has major responsibilities for overseeing the Community Mental Health Center program. As part of

these responsibilities, it is concerned with CMHC program evaluation. The concerns include developing Guidelines (standards) for CMHC Program Evaluation, and for developing Technical Assistance programs. The most important roles as relates to program evaluation are played by: Program Analysis and Evaluation Branch of the Office of Program Development and Analysis; the Program Evaluation Specialist assigned to the Mental Health Services Development Branch in the Division of Mental Health Service Programs; the Technical Assistance Committee of the same branch and division; and the Chief of the Quality Assurance Program in the Mental Health Care and Service Financing Branch in the Division of Mental Health Service Programs. Secondary but important roles are played by the Regional Office/Central Office Task Force on Program Evaluation; the head of the Mental Health Service Development Branch; the Director, Division of Mental Health Service Programs; the Survey and Reports Branch of the Division of Biometry and Epidemiology; the Division of Manpower and Training Programs; and the Staff College.

Alcohol, Drug Abuse and Mental Health
Administration Regional Offices

General Functions

There are ten Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) Regional Offices across the United States. These regional offices are part of the Public Health Service-Alcohol, Drug Abuse and Mental Health Administration. Organizationally, they are not subunits of the National Institute of Mental Health but rather they relate to NIMH through a series of formalized liaison relationships. Despite their position vis-a-vis-NIMH, these Regional Offices play key roles in relation to Community Mental Health Centers. These key roles involve grant review and approval, contract compliance and monitoring, and the provision of technical assistance.

Specifically, the functions of the Regional Offices are defined as follows:

Directs and coordinates programs and activities to improve access and availability of community and state mental health programs.

Promotes the planning, development and delivery of quality mental health, drug abuse and alcohol services throughout the region.

Assists in mental health program development at state and local levels through the provision of professional consultation, guidance and technical assistance including interpretation of national policies and guidelines to grantors, prospective grantees, State and local officials and non-profit organizations.

Analyzes programmatic data, reviews and recommends action on grant applications and contract proposals, and provides continuous programmatic monitoring of division grants and contracts for compliance with applicable laws, regulations, policies and performance standards.³⁴

Organization of Regional Office

Each Regional Office is headed by a Chief. This Chief, a mental health professional, supervises the activities of the office and the professional staff. The professionals (social workers, psychologist, psychiatrists) implement the review and monitoring functions and have a substantial role in developing technical assistance activities. It should be noted that most of the staff have no expertise in evaluation and most offices have not designated any program evaluation specialists.

The Ten Regional Offices

There are ten Regional Offices which correspond with the ten DHEW regions. These are as follows:

<u>Region</u>	<u>Location</u>	<u>States Covered</u>
I	Boston, MA	Maine, Vermont, N. Hampshire, Connecticut, Rhode Island
II	New York, NY	New York, New Jersey, Puerto Rico, Virgin Islands
III	Philadelphia, PA	Delaware, Maryland, Pennsylvania, Virginia, W. Virginia, Washington, D.C.
IV	Atlanta, GA	Alabama, Florida, N. Carolina, Georgia, Kentucky, Mississippi, Tennessee
V	Chicago, IL	Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin
VI	Dallas, TX	Arkansas, Louisiana, N. Mexico, Oklahoma, Texas

<u>Region</u>	<u>Location</u>	<u>States Covered</u>
VII	Kansas City, MO	Iowa, Kansas, Missouri, Nebraska
VIII	Denver, CO	Colorado, Montana, N. Dakota, S. Dakota, Utah, Wyoming
IX	San Francisco, CA	Arizona, California, Nevada, Hawaii, A.S., W.I., Guam, Trustte
X	Seattle, WA	Alaska, Idaho, Oregon, Washington

General Relationships with NIMH

The Regional Offices interact with several key NIMH offices.

1. Field Liaison Branch, which has as its main focus as "serves as liaison and coordinating point between mental health program officials on PHS Regional Staffs and headquarters, NIMH."³⁵
2. Division of Mental Health Service Programs "provides consultation to DHEW Regional Office staffs and participates with Regional Offices in consultation to applicants, grantees and other legal, regulation, fiscal, program and management problems."³⁶
3. Office of Program Support

Regional Office Roles in Relationship to CMHC Program Evaluation

The Regional Offices have a number of important responsibilities in relationship to CMHC Program Evaluation activities. These activities include:

1. Monitor through grant reviews and on-site visits, CMHC compliance with fulfilling mandates in the area of program evaluation—spending 2% of the CMHC's funds on evaluation, developing the needed technical activities, e.g. consumer feedback and outcome studies, preparing an Annual Evaluation Report and Plan, and holding a community forum.
2. To plan, develop and fund technical assistance and training activities for CMHC's in the area of evaluation, and
3. To work with the NIMH Task Force on Program Evaluation in the areas of policy formulation and the development of Technical Assistance projects.

Summary

The ten ADAMHA Regional Offices represent by law and regulations

important bodies in relation to CMHC's. Their power stems from their roles in approving grants, monitoring CMHC activities and in developing technical assistance activities. Through these mechanisms and by membership on the NIMH Task Force on Program Evaluation, they have an important role in implementing the requirement of Public Law 94-63 as relates to CMHC Program Evaluation activities.

National Council of Community Mental Health Centers

Introduction

The National Council of Community Mental Health Centers, Inc., (NCCMHC) is the lobbying or interest group for Community Mental Health Centers. The goal and purpose of the National Council are described as follows in the by-laws of that organization.

Article II-Purpose and Goal

Section 1-Purpose. The purpose of the National Council of Community Mental Health Centers, Inc. shall be to (a) promote the concept, funding and delivery of community mental health services; (b) provide technical guidance and support for it's members; (c) serve as a means for cooperation and communication between individual community mental health centers; and (d) work in liaison with other human service agencies as a protagonist for community mental health.

Section 2-Goal. The goal of the Council shall be the establishment and maintenance of effective and comprehensive community mental health programs for all persons in the United States.³⁷

History

The existence of the National Council as a "protagonist" organization for CMHC's is comparatively new. The Council began in a small informal manner out of a meeting of a half-dozen or so CMHC Directors in the late fall of 1969. The idea for the organization grew out of Center's Directors concern in the areas of legislation and funding and the felt need for a lobbying organization. The Council was incorporated in August of 1970

and run by a part-time Director, who also headed a legislative/governmental affairs consulting firm. According to most observers, this part-time Director was the National Council for the period of 1970-1974. Through painstaking activity, membership was gradually built up from CMHC's or other mental health agencies. Organizationally during this period, Regional networks in the ten ADAMHA regions were established and a Board of Directors formed. It should be noted that membership in the regional networks and the Board had been limited to CMHC staff members.

In 1975, the National Council went through a period of drastic changes:

- It's membership had reached almost 500 Centers and Mental Health agencies.
- It was decided to hire a full-time Executive Director.
- The by-laws of the organization were changed to recognize the increasingly important role being played by community leaders and laymen in CMHC's. The new by-laws called for formalizing roles for community leaders by (a) having in each region a Staff Director (CMHC professional) and a Community Director (non-mental health professional elected from CMHC community advisory boards) and (b) an alternating every other year in the presidency of the National Council between a professional and a non-professional.
- During the same period, the Board also increased the times it would meet during the year.
- Finally, the groundwork was laid for the establishment of Councils.³⁸

Current Status, Organization and Structure

General Information

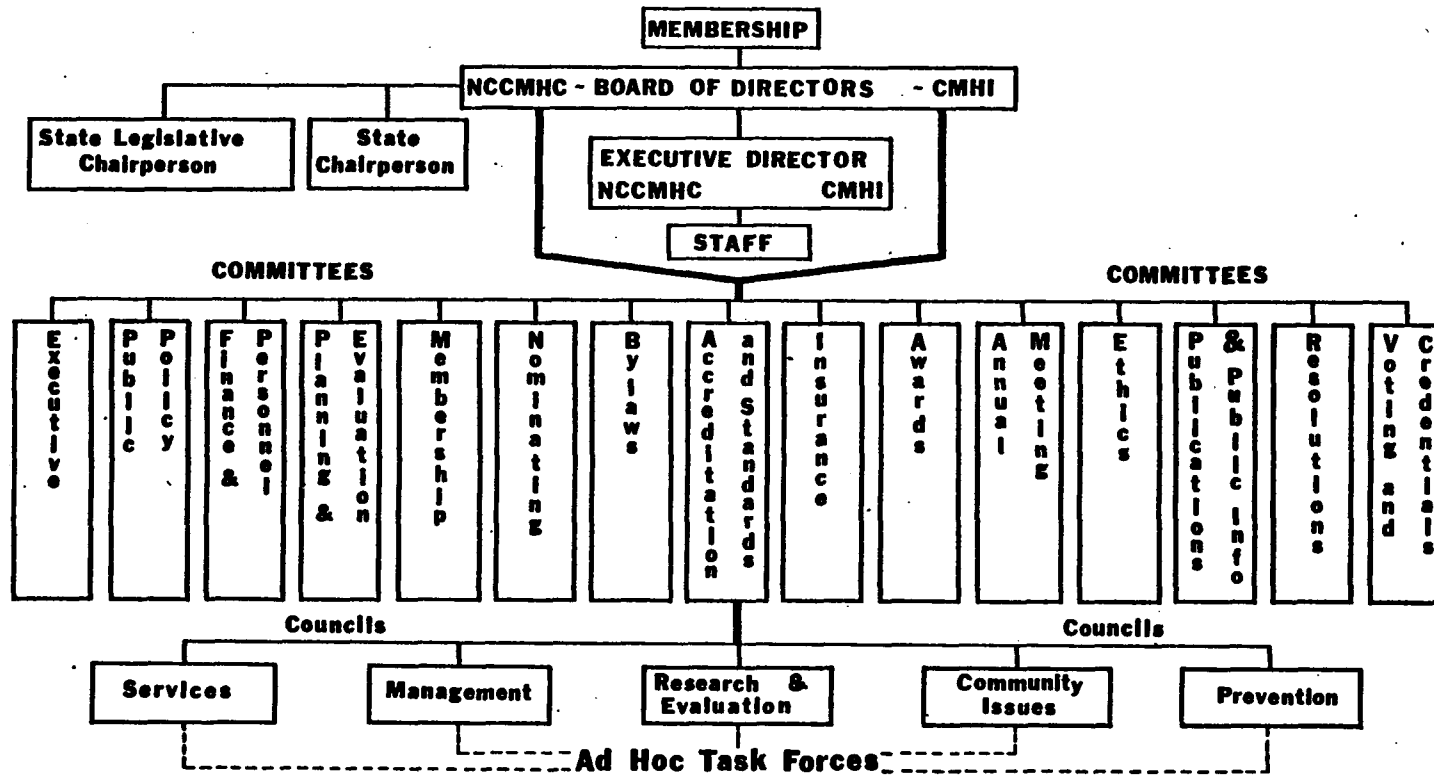
The National Council, at the present time, has a membership of 715 Centers, a board of 26 that meets three times annually, a budget of

approximately \$450,000.00 annually, sponsors an Annual Program Meeting which usually attracts from 1000-1200 participants and maintains it's office in Washington, D.C.

Figure 3 provides a detailed overview of the organization of the National Council.

FIGURE 3

**NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS
ORGANIZATIONAL STRUCTURE**



The Board of Directors

The National Council has a Board of Directors consisting of 26.

The duties of the Board (as detailed in the Board Handbook) are as follows:

1. To determine the goals and policies of the National Council of Community Mental Health Centers, Inc.
2. To identify areas of interest and/or concern in the field of community mental health and to adopt appropriate positions or initiate approved actions.
3. To develop legislative action on behalf of Community Mental Health Centers.

The duties of each member of the Board of Directors, in addition to the above, shall be:

1. To serve in appointed capacities on Board Committees in order to enhance the efforts of the National Council.
2. To attend all Board meetings.
3. To stimulate interest and knowledge of community mental health issues and legislation.⁴⁰

The twenty-six members of the Board include six officers-President, President-Elect, Vice President, Treasurer, Secretary and Immediate Past President-and twenty board members from each of the ten regions. There is a Staff Director and Community Director. It should also be noted that the Chairpersons of the five Councils are ex-officio members of the Board.⁴¹

To carry out it's functions, the Board meets three times a year. Once in connection with the Annual NCCMHC Business and Program Meeting and at two other separate occasions.⁴² The Board has, in order to facilitate maximum attention to all aspects of the NCCMHC's operations, established several committees. These committees, which meet at least twice a year, are:

- Nominating Committee
- By-laws Committee
- Finance and Personnel Committee
- Accreditation and Standards Committee (addresses all accreditation and standards matters of concern to the membership)
- Membership Committee
- Public Policy Committee (makes recommendations to the Board of Directors regarding positions on legislative issues; cooperates with the Deputy Director for Government Affairs in the implementation and monitoring of the legislative network)

- Insurance Committee
- Planning and Evaluation Committee
- Executive Committee
- Annual Meeting Committee
- Awards Committee
- Ethics Committee
- Publications and Public Information Committee (recommends general policy for the National Council News, all other publications and all public information activities)
- Voting and Credentials Committee
- Resolution Committee⁴³

Regional Structure

The NCCMHC Has established a structure of ten regional networks. These regions coincide with the regional service areas established by the Department of Health, Education and Welfare. The general purpose of these regional structures are to (1) maintain and recruit membership; (2) provide a system of liaison from the Board of Directors to Centers in the region; (3) to educate and inform their regions about community mental health issues and about NCCMHC activities; (4) to hold an Annual Regional Meeting to promote the interchange of programmatic information and to discuss NCCMHC related business; and (5) to develop a system of state coordinators and legislative chairpersons. The major responsibility for overseeing the development of these regional structures lies with the Regional Staff Director (mental health professional) and the Regional Community Director (citizen board member). These directors are elected by each region and serve on the NCCMHC Board of Directors.⁴⁴

As was noted above, an integral component of this regional structure is a system of State Chairpersons and State Legislative Chairpersons. These State Chairpersons have the following role:

...(they) are the first link between the NCCMHC Board and staff and the individual member centers. Their main areas of responsibilities are in the areas of information dissemination and membership recruitment. They also assist in planning state and regional NCCMHC meetings and coordinate various activities with the regional directors and legislative chairpersons.⁴⁵

The State Legislative Chairpersons have as their responsibilities (1) developing a legislative network with the state (2) maintaining legislative liaison with the National Council and the governmental affairs specialists on staff.⁴⁶

It is the Regional Structure with the subsequent divisions along state lines that provides the National Council with it's main methods of continuing membership input and with the ability to mobilize members around key legislative issues.

Councils

The Board of the National Council has established five Councils. These Councils are the Council on Services, Council on Management, Council on Research and Evaluation, Council on Community Issues and the Council on Prevention. The role of the Councils are described as follows:

In order to facilitate the opportunities for input from the membership in relation to the major issues of concern in the field of community mental health, the Board of the National Council of Community Mental Health Centers has established five Councils which report directly to the Board of Directors. The Councils are charged with the responsibility of examining critical issues which affect the field of community mental health and preparing position papers for review by the Board of Directors. These position papers become National Council policy upon adoption by the Board of Directors and are distributed to the membership and other interested parties.

When appropriate, each of these five Councils may request authority from the Board of Directors to establish ad hoc task forces to assist in the preparation of position papers. The membership of such task forces is not limited to National Council members.⁴⁷

Each Council is composed of a Chairperson and five members. The members of the Council must be associated with Full Member centers or Associate Members centers but should be representative of the broad constituency of the National Council. Each member shall be appointed to a three year term (with the possibility of reappointment for a second three year term) by the President with the advice of the Board of Directors.

The President, with the advice of the Board of Directors, shall also appoint the Chairperson of each Council for a term of one year with the possibility of reappointment for two additional terms. The Chairperson of each Council shall attend all meetings of the Board of Directors as an ex-officio member (without voting privileges).⁴⁸

The responsibilities of the Chairpersons and Councils are detailed below:

Council Chairpersons report to the Board of Directors at each regular meeting. In addition, each Council is required to submit an annual report to the Board of Directors. This report should cover activities of the Council during the year, special projects undertaken, task forces created and appropriate recommendations for action by the Board of Directors. Each Council shall also submit an annual financial report.⁴⁹

Annual Meeting

Each year for the past seven years, the National Council has sponsored an Annual Meeting. This Annual Meeting runs from three and one-half to four days. It's main thrust has been on program development, and it features workshops, seminars and lectures. A secondary feature has been to promote the interchange of ideas between CMHC's and to disseminate information about the National Council and it's activities. One component of the Annual Meeting has been the Business meeting at which time the membership of the Council can vote on board policy resolutions for the Council. The location of the Annual Meeting varies from year to year across the United States and usually attracts from 1000 to 1200 attendees, mostly representatives of CMHC's.

Staff

The staff of the National Council now consists of an Executive Director, a Deputy Director for Governmental Affairs, a Director of Public Information and Training, an Administrative Assistant for Governmental Affairs, an Administrative Assistant, one and one-half secretarial workers

and a part-time accountant.⁵⁰

The specific functions of each of the professional staff members are outlined (briefly) below:

Executive Director-General leadership to the organization; management of the Council; direction of the office and the implementation and supervision of the policies adopted by the Board. Coordinate activities with other national organizations, lay groups and liaison with government offices.

Deputy Director for Governmental Affairs-Monitors all legislative proposals, works with Congressional leaders, works with NCCMHC membership on legislation, works with Federal offices on regulations, guidelines and Technical Assistance projects.

Administrative Assistant for Government Affairs-Assists Deputy Director for Governmental Affairs in the above mentioned activities.

Director of Public Information and Training-Has responsibility for all publications and newsletters, developing public information documentations, help plan and conduct workshops and training institutes and work on the Annual Meeting.

Administrative Assistant-Has primary responsibilities for activities associated with the Annual Meeting and for specific training activities.⁵¹

The professional staff, as was indicated in the job descriptions, enables the National Council to work on a substantial number of issues with a wide range of organizations. These activities can perhaps be summarized as follows:- (1) lobbying and legislative policy development and promotion (2) liaison with governmental organizations (3) liaison with other national organizations (4) information dissemination (5) to provide workshops and educational activities (6) maintaining communication and fostering cooperation of the membership and (7) assisting the Board of Directors in their activities.

Financing

Financing the named activities of the Board, staff and five Councils requires a budget of approximately \$450,000.00. The 1978/79 budget indicates that the main sources of income for the National Council are:-

Membership dues (\$300,000. or 60+%); the Annual Meeting (\$60,000. or 15%); Grants and Contracts from NIMH and other government agencies (\$55,000. or 15%); and other minimal resources. The major expenditures are for salaries, travel (Board and staff), printing and funds for the Council.⁵²

Summary

The National Council of Community Mental Health Centers, Inc., has become, in the eight years since incorporation, a substantial and influential organization. It operates on numerous different activities through a complex system of organizational units-Board, staff, Councils, and Regional and State networks. A survey of it's activities (The Board Handbook, the NCCMHC Annual Report, National Council News, and several articles in professional journals) would indicate it has become the chief "protagonist" for Community Mental Health Centers in the United States.

The Council on Research and Evaluation

Functions of Councils in General

The five Councils were established by the Board of Directors through actions in the latter part of 1975 and the early part of 1976. The mission of the Councils, as noted earlier, was to "examine critical issues which affect the field of community mental health and preparing position papers for reievw by the Board of Directors."⁵³ According to the Executive Director, establishment of the Councils was a recognition by the Board that technical expertise was needed to help them deal with the blossoming issues in community mental health and react to the specifics detailed in Public Law 94-63.⁵⁴

Functions of the Council on Research and Evaluation

The responsibilities assigned to the Council on Research and Evaluation reflect both the broader issues and the issues associated with Public Law

94-63. The function of the Council was defined as follows:

The Council on Research and Evaluation has broad responsibilities for research and evaluation activities. This may include, but not be limited to, such areas as accreditation, data collection, program evaluation, Professional Standard Review Organization, pure and applied research, utilization review, etc. The Council will, with direction and consent from the Board of Directors, establish priorities, appoint ad hoc task forces, prepare position papers, and carry out other activities necessary to further the use and dissemination of research and evaluation methods and result, and of evaluation procedures in community mental health centers.⁵⁵

The charge to the Council on Research and Evaluation was both broad and general, since, according to the Executive Director, the Board wanted to encourage flexibility and lacked the expertise to more rigorously define the functions.⁵⁶

Board Supervision of Council Activity

Board supervision of all Councils and their activities were built in through the following mechanisms: (1) appointing the Chairpersons to be ex-officio members of the Board and requiring that they report at each Board meeting; (2) submit an annual report and an annual financial report; and (3) through the assignment of NCCMHC staff to work with each Council.

Composition of the Council on Research and Evaluation

The Council on Research and Evaluation developed through the following steps.

1. Dr. John Bell*, an outstanding evaluator from a western state, who had worked as the key NCCMHC Board member previously, was designated as Chairperson in the early spring of 1976.
2. Board members were asked to provide names of candidates to the Council, to the Executive Director and the then-President of the National Council. In providing these names, most Board members solicited input from different centers in the region.

*fictitious name

3. Candidates being considered were then asked to submit curriculum vitae to the National Council.
4. The vitae, which numbered over forty, were reviewed primarily by the Chairman of the R&E Council, and secondarily by the President of the National Council.
5. In reviewing these vitae, consideration was given to these factors- expertise and experience in evaluation, geographic location, sex, age, professional discipline.
6. It should also be noted that the "political" consideration also was given credence in relation to one position. Based upon discussions between the three key decision makers, final membership for the Council was determined. The original group consisted of the following members in addition to Dr. Bell*, who was in his forties, a Ph.D., psychologist from a CMHC in Region 8:

Lucy Dowd*-thirties-Master in Urban Planning but an experienced evaluator from a CMHC in Region 9.

Margie Harper*-late forties-with Ph.D. in psychology, who had been a program evaluator but who was in an administrative position at her center in Region 10.

Robert Hayward*-a psychiatrist in his early forties who had clinical administrative responsibilities at a CMHC in Region 6.

Jeanne Kramer*-a Ph.D. psychologist in her early thirties, who was a director of an evaluation program at a Region 4 CMHC.

The author-a social worker in his early thirties, who was the director of an evaluation unit at a Region 2 CMHC.

The terms of the members were determined by drawing lots at the first Council meeting in October 1976. Based upon the lot drawn, the

*fictitious names

terms for each of the members were as follows: Dr. Bell-1978; the author-1978; Lucy Dowd-1979; Dr. Hayward-1979; Dr. Harper and Dr. Kramer-1980. The term ended as of the annual meeting (February) of the year cited.

Council Orientation and Activities During the Period
October 1976-December 1977

During the first year and one quarter of the Research and Evaluation Council, there was only limited attention paid to the issue of implementation. The following issues assumed major attention during the course of the three Council meetings.

1. Review and Critique on the Joint Commission for the Accreditation of Hospitals-Standards for Program Evaluation in Community Mental Health Centers

The Joint Commission had, originally under contract from NIMH and then independently, developed a series of standards for accrediting CMHC's. (Accreditation was of possible long-range benefits to non-hospital based CMHC's to make them eligible for third party reimbursement payment.) These standards were to be utilized in a pilot test of some sixty CMHC's. The Board Committee on Standards and Accreditation had worked with the JCAH on writing these standards. The Research and Evaluation Council felt that these standards might become the norms for the field and there were substantial questions as to the vast array of specific and costly requirements detailed. (Dr. Harper played the major leadership role in this area.)⁵⁷

2. The Establishment and Report of a Task Force on Peer Review and Quality Assurance

The issue of Peer Review Quality Assurance and the relationship of CMHC's to Professional Standard Review Organizations were causing substantial apprehension in the field. The Board made a special request to the Research and Evaluation Council to develop a comprehensive

report with recommendations on the topic. Lucy Dowd of the Research and Evaluation Council took a major leadership role in establishing and working with this Task Force. The Task Force consisted of Lucy Dowd and the author from the Research and Evaluation Council, a psychiatrist from the NCCMHC Board Committee on Accreditations and Standards, a CMHC Center Director from a Tennessee CMHC and two specialists from NIMH. All members of the committee were experts on the subject. The Task Force met once and had numerous correspondence. A report, with the following recommendations, was sent to the Board:

NIMH study the costs and effectiveness of various quality assurance systems and sponsor multiple CMHC comparisons; that NCCMHC establish a liaison with the PSRO National Advisory Council and that State PSRO organizations; that NIMH develop a complete package of conferences and workshops to train CMHC staffs in quality assurance techniques, develop a clearinghouse to share new information among centers and help develop new models of quality assurance, especially in the area of ambulatory care.⁵⁸

3. A Preliminary Review of the Rights of Patients in Research Studies

Based upon a preliminary review of the issues, the Council issued a brief report that recommended that each CMHC establish a committee consisting of professional and consumers to review all research proposals involving patients.⁵⁹

4. Implementation Related Activities

The Council did become involved peripherally with three sets of activities.

(a) Two members of the Council (Dr. Kramer and the author) consulted with two NIMH officials in reviving the sixth draft of the NIMH guidelines on CMHC program evaluation. The consultation occurred at a very late stage in development of guidelines. Earlier, draft sets had been issued and distributed to ADAMHA Regional Office staff and to CMHC's. (b) The Council established liaison relationships with NIMH Office of Program Development and Analysis and the Mental Health Services Branch. This

Liaison relationship was implemented by having lower level staff from the sections attend one session at the meetings of the Research and Evaluation Council. At these meetings, the NIMH staff would present the various NIMH projects or activities in evaluation that were being planned or being implemented. Research and Evaluation Council members would comment on these activities and projects. Research and Evaluation Council members would also propose new ideas and suggest new projects or new procedures. It should be noted that the new procedures were useful in that they provide some R&E Council input into NIMH decision making but there were limited. One of the major limits of contact was the fact that the input was informal and occurring with NIMH secondary level officials. The higher level officials with more authority were not involved in these discussions nor did there exist any formal relationship so that the R&E Council was informed about NIMH actions or responses to it's recommendations. Moreover, another limiting factor was that the liaison relationship existed only with two offices with the NIMH Central Office and did not include any relationship with the ten Regional Offices which have major control over CMHC related activities. (c) A third area in which the Research and Evaluation Council became limitedly involved with the implementation process was in the area of technical assistance. Technical assistance refers to the provision of aid to CMHC's to assist them in fulfilling the mandates of Public Law 94-63 (CMHC Act of 1975). The legislation specifically indicates that NIMH is required to spend an amount equal to 2% of all the funds allocated to CMHC funding to provide technical assistance to CMHC's. Yet, there existed major problems in the area of technical assistance. These included: NIMH under-financing of the program, lack of input by CMHC's into program development and some questionable types of projects sponsored. The Research and Evaluation

Council drafted some general policy statements on technical assistance in the area of program evaluation. Below are excerpts from these position statements:

That each regional office utilize a core of consultants drawn from CMHC's who are considered to be program evaluation experts in these regions. These consultants should be paid to (a) help plan all evaluation activities and technical assistance programs in the region (b) review and comment on the Center's Annual Evaluation Report (c) provide consultation to the majority of CMHC's which do not have effective evaluation components.

Regional Offices, in setting up evaluation conferences, should be cognizant of the need to pay the travel and per diem expenses of one person from each center.

It is recommended that these workshops be organized, run by and geared to CMHC staff.

Training citizen boards should include training such boards to effectively work with evaluators and evaluation data.⁶⁰

The impact of the work in technical assistance is quite limited due to the lack of any formal relationships to higher authorities at the NIMH Central Office and lack of connecting links to Regional Offices.

Lack of a Constituency Base for the Council

Despite the fact that the Council was active, it had no direct constituency. In fact, aside from members of the NCCMHC Board and key NIMH officials, knowledge of its existence was limited. CMHC and other mental health agency staff, including those which were members of NCCMHC, did not know of its existence and activities. There existed no mechanism for input from program evaluators and mental health agency managers in relation to R&E Council policy positions. The result of this gap (a) left the Council open to "charges" that it was elitist and its positions were not representative of the positions of practitioners and (b) it deprived the Council of a potential constituency which would strengthen its position. Moreover, there existed within the Council some feelings

by selected members that it did not want to go public and a satisfaction with an elitist ideology.

Process Factors that Limited the Council Activities

In addition to the lack of a constituency and the neglect of strategies to develop this constituency, the Research and Evaluation Council also was handicapped by a number of process factors.

1. The R&E Council did not clearly define it's role and purpose, and members were confused over what represented appropriate functions. Moreover, there was only limited conceptual concern with a role in influencing the implementation process.
2. Resulting from this confusion, the activities of the Council were often helter-skelter. Moreover, frequently the Council functioned as a passive reactor rather than an aggressive actor geared towards certain goals.
3. The communication and decision making centered around the Chairperson. Council members roles were usually circumscribed. This factor made it difficult to have important decisions made between meetings. It also frankly limited the manpower and activities of the Council. Members generally were very limited in their participation in task activities.

Summary

The Research and Evaluation Council, in the first year and one half of it's existence, represented a group that (1) grew in importance and influence, (2) but whose actions were limited by the fact that it lacked a clearly defined role and focus, lacked a constituency base and it's internal process did not fully utilize the skills of it's members for task achievement.

CHAPTER III

FOOTNOTES

¹ Franklin D. Chue and Sharland Trotter, The Mental Health Complex. (Washington, D.C.: The Center for the Study of Responsive Law, 1972), p. III-2.

² Ibid., p. III-3 and 3.

³ Ibid., p. III-6.

⁴ Lucy Ozarin, "Community Mental Health: Does It Work? Review of the Evaluation Literature," in Walter Barton, and Charlotte Sanborn, (Eds.), An Assessment of the Community Mental Health Movement. (Lexington, Mass.: D.C. Heath and Company, 1977), p. 122.

⁵ U.S. Congress Senate, Health Revenue Sharing and Health Services Act of 1975. Title III-Community Mental Health Centers Amendments. Public Law 94-63, 94th Congress, July 1975, S-66

⁶ Ibid.

⁷ Howard Davis, Charles Windle and Steven Sharfstein, "Developing Guidelines for Program Evaluation Capability in Community Mental Health Centers," in Evaluation. 1977, p. 25.

⁸ Ibid., p. 31.

⁹ National Institute of Mental Health, "Guidelines for Program Evaluation in Community Mental Health Centers," in Evaluation. 1977, p. 31.

¹⁰ Ibid., p. 31.

¹¹ Ibid., p. 31 and 32.

¹² Ibid., p. 33.

¹³ Ibid., p. 33.

¹⁴ Ibid., p. 34.

¹⁵ David F. Musto, "The Community Mental Health Movement in Historical Perspective," in Walter Barton and Charlotte Sanborn, (Eds.), An Assessment of the Community Mental Health Center Movement. (Lexington, Mass.: D.C. Heath and Company, 1977), p. 7.

¹⁶ Mental Health-Mental Retardation Report, June 20, 1978, "Budget of NIMH," p. 2.

¹⁷ National Institute of Mental Health, NIMH Organization Handbook. (Rockville, Md.: National Institute of Mental Health, 1977), p. 1.

¹⁸ Ibid., p. XI-1.

¹⁹ Ibid., p. 1.

²⁰ Ibid., p. 1.

²¹ Ibid., p. 1-2.

²² Ibid., p. V-1.

²³ Ibid., p. VII-5.

²⁴ Ibid., p. IV-1.

²⁵ Ibid., p. IV-2a.

²⁶ Ibid., p. IV-2a.

²⁷ Ibid., p. IV-3 and 4.

²⁸ Ibid., p. VIII-2.

²⁹ Ibid., p. VIII-2.

³⁰ Ibid., p. VIII-3 and 4.

³¹ Ibid., p. VIII-3.

³² Interview with the Acting Chief of NIMH's Program Analysis and Evaluation Branch, July 26, 1978.

³³ Isabel Davidoff, Marcia Guttentag and Joan Offut, (Eds.), Evaluating Community Mental Health Services: Principles and Practice. (Rockville, Md.: NIMH Staff College, 1977), DHEW #77-465, p. V.

³⁴ U.S. Department of Health, Education and Welfare, Public Health Service, "Functions of Alcohol, Drug Abuse and Mental Health Administration Regional Offices," Federal Register. Vol. 42, No. 232, December 2, 1977.

³⁵ National Institute of Mental Health, NIMH Organizational Handbook. op.cit., p. 1-1.

³⁶ Ibid., p. VIII-2.

³⁷ National Council of Community Mental Health Centers, Board Handbook. June 1978, Washington, D.C., (mimeo), p. 3.

³⁸ Telephone interview with the Director of Public Information and Training of the National Council of Community Mental Health Centers, July 8, 1978.

³⁹ National Council of Community Mental Health Centers, Board Handbook. op.cit., p. 28.

- ⁴⁰ ibid., p. 24.
- ⁴¹ ibid., p. 25-28.
- ⁴² Telephone interview with the Executive Director of the National Council of Community Mental Health Centers, May 24, 1978.
- ⁴³ National Council of Community Mental Health Centers, Board Handbook. op.cit., p. 31-33.
- ⁴⁴ ibid., p. 55-58.
- ⁴⁵ ibid., p. 59.
- ⁴⁶ ibid., p. 66 and 67.
- ⁴⁷ ibid., p. 37.
- ⁴⁸ ibid., p. 37-38.
- ⁴⁹ ibid., p. 38.
- ⁵⁰ ibid., p. 43.
- ⁵¹ National Council of Community Mental Health Centers, "Report of the Finance and Personnel Committee," June 16, 1978, Washington, D.C., (mimeo), p. 8-12.
- ⁵² ibid., p. 6-8.
- ⁵³ National Council of Community Mental Health Centers, Board Handbook. op.cit., p. 32.
- ⁵⁴ Telephone interview with the Executive Director of the National Council of Community Mental Health Centers, May 24, 1978.
- ⁵⁵ National Council of Community Mental Health Centers, Board Handbook. op.cit., p. 39.
- ⁵⁶ Telephone interview with the Executive Director of the National Council of Community Mental Health Centers, May 24, 1978.
- ⁵⁷ National Council of Community Mental Health Centers, Annual Report-1977. Washington, D.C., (mimeo), p. 20.
- ⁵⁸ ibid., p. 21.
- ⁵⁹ ibid., p. 21.
- ⁶⁰ ibid., p. 22-23.

CHAPTER IV

PROGRAM DEVELOPMENT

The Opportunity for Action

Through the first year of the existence of the Research & Evaluation Council, the author's opportunity to influence the direction of the Council's activity was quite circumscribed. His role was limited to being a Council member. Even though the author was very active as a member, he had limited or no contact with National Council of CMHC Board or staff or upper echelon NIMH officials. Furthermore, the author was, due to his position, unaware of certain types of information.

The prospects for the author being able to exert significant leadership appeared dim. The author's term as a member of the Research & Evaluation Council, which had been decided by lot, was the shortest. His membership on the Council was due to expire as of February 1978. Then, abruptly, events changed this dim outlook. Dr. John Bell, Chairperson of the Research & Evaluation Council, was appointed to the Task Panel on the Assessment of Community Mental Health Center's of the President's Commission on Mental Health. As Dr. Bell became more involved with his activities on the President's Commission on Mental Health, he had less time for activities of the Council on Research & Evaluation. Therefore, at the Chairperson's request and with the agreement of the then-President of the NCCMHC Board and the Executive Director, the author was named the Co-Chairperson of the Research & Evaluation Council in late October 1977. The author was informed at that time he was to be reappointed to the Research & Evaluation

Council for a three year period and would officially assume the role of Chairperson as of February 1978. It was this change that provided him with the opportunity to develop the program of action which is outlined in the pages which follow.

Analyzing the Problem

General Problems of Implementation

Implementation is a difficult task. The difficulty lies in general factors which were enumerated previously: (a) it involves numerous actors and numerous levels of decision making; and (b) it is a process about which we have limited knowledge of the important factors that are influential. The implementation process as relates to the Program Evaluation mandates included in the CMHC provisions of Public Law 94-63 is further complicated by (a) the complexity of the organizational structure of the implementing agencies, e.g. the several bureaus and sections in the NIMH Central Office- The Mental Health Services Support Branch, the Office of Program Development and Analysis, the Division of Mental Health Service Programs and the ten ADAMHA Regional Offices; (b) lack of clarity of the specific roles of the forementioned organizations as relates to the implementation process; and (c) the timing of the project that was to be developed was such that it excluded interventions aimed at influencing the development of guidelines (which is a comparatively easier process to influence), and was geared to influencing the processes of resource distribution, oversight and enforcement, patterns of communication and the attitudes and dispositions of the implementors towards the policy. Influencing these later stages of the implementation process required more intricate strategies.

An Analysis of the Implementation Problems as Relates to the Program Evaluation Requirements of the CMHC Amendment of Public Law 94-63

As was noted, this project focuses on effecting the implementation

processes that followed the development of CMHC Program Evaluation Guidelines. The implementation processes that were of major concern were in the areas of (a) resource allocation (b) the attitudes and disposition of implementors towards the policy (c) the communications and feedback loops and (d) the oversight and enforcement process.

Based upon informal input and information from the NCCMHC Board and staff, members of the Research & Evaluation Council, CMHC program evaluators, selected ADAMHA Regional Office staff and the results from surveys from the CMHC's in Regions 2 and 5, it was possible to pinpoint key and important issues. These are delineated as follows:

(a) Resource Allocation: (1) It was estimated that only one-quarter or 25% of the funds that NIMH had available (under PL 94-63) to spend on providing technical assistance to CMHC's were actually being utilized for that purpose. Only \$1,000,000.00 out of a possible \$4,000,000.00 was being utilized for technical assistance by NIMH. Technical Assistance monies were being used to fund direct services. This lack of funding reduced the number of technical assistance projects sponsored by the NIMH National Office and by the ADAMHA Regional Offices. Program evaluation technical assistance activities were thus quite limited.¹ (2) No additional funding was being provided to either the NIMH Central Office or to the ADAMHA Regional Offices for increased staff to assist in monitoring the implementation of program evaluation mandates or to assist in the development of technical assistance projects.² (3) There was a great variation between the ADAMHA Regional Offices as to the per cent and amount of technical assistance funds used to develop program evaluation projects. (4) There existed an informal policy both at the NIMH Central Office and among many of the ADAMHA Regional Offices that made it impossible for CMHC's to receive technical assistance funds to train or provide consultation to

other CMHC's.

(b) The Attitudes and Dispositions of Implementors Toward the Policy: (1) Basically, aside from a few individuals in the NIMH Central Office and a few numbers in the ADAMHA Regional Offices, the implementors knew little or nothing about program evaluation and it's role in CMHC's and actually cared less. (2) There was a variation in attitudes, to a limited degree, between NIMH Central Office and the ADAMHA Regional Offices. The NIMH Central Office was somewhat more interested in the subject than the ADAMHA Regional Offices. A number of factors affect this difference: (a) the NIMH Central Office was, both physically and psychologically, nearer to Congress (the legislative branch) and knew of the interest of that body in the subject (b) the NIMH Central Office was more acutely aware of the activities of the President's Commission on Mental Health and their interests in the assessment of the CMHC program (c) there were, as noted above, more experts in evaluation to the NIMH Central Office staff.³ (3) ADAMHA Regional Office staff looked askance at any requirements that increased their "monitoring" activities. They saw themselves primarily in the role as "program promoters or developers" rather than enforcers. Moreover, since they often felt overwhelmed with existing tasks and had limited knowledge about evaluation, their primary motivation was to ignore the policies on evaluation.⁴

(c) Communication: (1) As was noted, numerous CMHC's were not sent copies of the Guidelines and were unaware of the program evaluation requirements. (2) CMHC's had no input into the development of technical assistance projects by the NIMH Central Offices. (3) In most ADAMHA regions, CMHC's had no input into the development or the evaluation of the effectiveness of programs sponsored with technical assistance funds. (4) In many regions, CMHC's were not aware of the technical assistance projects that were being

sponsored by the NIMH Regional Offices.

(d) Oversight and Enforcement Processes: (1) The Guidelines or the standards for evaluation were not uniformly distributed to all CMHC's and, thus, some Centers were unaware of their obligations. (2) There was a definitive lack of clarity, despite the Guidelines, as to what was operationally going to be expected of CMHC's. In verbal statements, different messages were emanating from the NIMH Central Offices, and from and among the ADAMHA Regional Offices. (3) Amongst the ADAMHA Regional Offices, there were substantial variations in their oversight operations which included both monitoring CMHC activities in evaluation and the persuasion process of offering technical assistance. The priorities given to both sets of oversight activities appeared in most cases to be minimal.⁵ (4) Given the factors mentioned in the earlier sections—resource allocation, disposition of the implementors and communication—it was evident that these negatively affected the oversight process.

Prior Limitations of the Research and Evaluation Council Activities on Implementation

The Council on Research and Evaluation, as was noted previously, (1) had not clearly defined its role and purpose (2) had only limited concern with influencing the implementation process (3) its activities were often helter-skelter and the Council was frequently a passive reactor rather than an aggressive actor (4) decision making and communications were centered around the Chairperson and, operationally, the roles and the activities of the members were limited (5) the Council operated as an elitist organization and lacked a constituency base. These factors meant that the author had to develop an appropriate program strategy to restructure the role and function of the Council on Research and Evaluation in light of the forementioned issues.

Developing Strategies and Goals for Action

Concern with Process and Task Goals and Strategies

In conceptualizing and developing a strategy for action, the author relied heavily on theoretical and experimental data described in the literature of the fields of social work (group work and community organizations) and organizational development. The literature overwhelmingly suggests that in successful project implementation, both process and task need to be prominent concerns. These concerns are expressed as follows:

There are at least two different kinds of goals in organizations, those goals which are reflected in an output of some kind which we will call "output goals" and those which are the ends of those who are charged with responsibility for maintenance activities, which we will call "support goals."⁶

The most significant factor affecting organizational productivity was found to be the interpersonal relationships that are developed, not just pay or working conditions.⁷

In the past and often in the present, productive effort has been seen as that which focused directly on the productivity of goods and services. Little attention has been paid to the processes by which such effort takes place; to do so has often been viewed as a waste of time. Increasingly, however, the relevance to task accomplishment of such activities as team maintenance and development, diagnosis and working through interpersonal and intergroup communication barriers, confrontation efforts for resolution of organizationally dysfunctional personal and interpersonal hangup and assessment and improvement of existing modes of decision making is recognized.⁸

Productive work tends to diminish as long as the structure of positions and roles remains unresolved or a subject of conflict. Once the role structure receives acknowledgement, however, the group members are free to turn their efforts to productive output.⁹

Given this information, it is quite obvious that process and task should, in successful projects, mutually interact and reinforce each other and, thus, concern must be focused on both.

Process-Strategies and Goals

Within the concept of process, there are a number of factors that need attention: (1) the clarity of the purpose of the group or organi-

zation (2) the nature of the group (3) general aspects of groups (4) communication within groups (5) the role of group members and their identification with the group, and (6) the role of the leader and his relationship with the group. The observations on these factors, drawn from group work and organizational development, were to be of value in the development of project strategies and goals.

(1) The Clarity of the Purpose of the Group or Organization: (1) Brager notes: "means without ends are blind."¹⁰ The comment correctly suggests that ends, goals and purpose are crucial. Without a clarity of purpose, groups become directionless. It is the purpose of the group that assists it in directing the energies and activities of the member and the group, that provides it with a sense of identification and legitimacy and enables it to present a "public face" to the outside world.

(2) The Nature of the Group: It is essential in developing strategies for action to understand the unique character of the Council on Research and Evaluation. The Council, operationally, falls somewhere in between being a primary group and being a formal organization. Although the Research and Evaluation Council is a component of a formal organization—the National Council of Community Mental Health Centers—operationally, the R&E Council is dependent on voluntary membership and voluntary participation. Members are not paid for their services, and thus, the degree of organizational control and sanctions over the actions of members is limited. In many respects, the Council on Research and Evaluation has the attributes of a voluntary association. The implications of this status are noted by Hage and Aiken:

Voluntary associations lie between primary groups and formal organizations; they have many of the formal attributes of organizations, but one way they differ is in the attributes of the members. Members are less likely to have formal roles; participation may be limited and membership apathy is a major problem.¹¹

These are important considerations for planning.

(3) General Aspects of Groups: Given the fact that the Research and Evaluation Council is a group, it is important to be cognizant about some basic facts about groups. Stogdill writes:

A social group is an interaction system. Interactions are a process in which the performance of one member serves as a stimulus to the response of another member, who in turn responds.¹²

Schwartz notes:

The group itself, by the nature of its central problem, by the activities in which it engages, and by the particular personalities it brings together, and creates its own conditions for success and failure.¹³

Vinter observes:

The group can be a deliberately structured influence system, in which changes are effected through social interaction with others.¹⁴

The implications of these observations are delineated in the discussions that follow.

(4) Communication within Groups: Communication within groups are important and essential to the group process. This fact is noted by several authors.

Stogdill writes:

Intercommunication merits attention as a special form of interaction because of the critical role it plays in formally structuring the organization.¹⁵

Hersey and Blanchard note:

A participative change cycle is implemented when new knowledge is made available to the individual...It is hoped that the group will accept the data and will develop a positive attitude and commitment in the direction of the desired change.¹⁶

Shaw suggests that "effective communication is the people's ability to understand each other; failure cause difficulty."¹⁷ Hollander observes:

Information is a valued resource and centrality in the information network and produces greater influence; meaningful participation requires relevant information.¹⁸

(5) The Role of Group Members and Their Identification with the Group:

Inherent in the success or failure of groups are issues of the members perceptions of their role and of the identification with the group. To a substantial degree, the member's participation in the group and its task activities are related to (a) the members sense of reward from the group. On this subject, Tannenbaum writes:

People are more likely to participate actively when their participation will make a difference, when they feel their efforts may help to influence a decision, establish a program, attain a goal, bringing about a state of affairs they want to gain...¹⁹

He further observes that:

Individuals have a need for affiliation,...to be given self-respect, self-esteem; a vehicle for self-fulfillment and a feeling of power and status.²⁰

(b) When members feel they have an input into group decision making. On this issue, Lowenstein et al indicated that "the more satisfied workers felt they participated in decision making."²¹ While Bass and Leavitt suggest that:

Other things being equal, plans will be more willingly executed by persons who have participated in developing them, than by persons who have been assigned to execute them after they have been developed by others.²²

(c) When the roles and functions of group members are clear, it is suggested that "the possibility of role conflict is reduced and a source of disequilibrium removed."²³

(6) The Role of the Leader and His Relationship to the Group: The role of the leader is crucial to the group's development and functioning.

Schwartz projects the role of the leader as follows:

The worker moves to keep the group alive least it be lost on the preoccupation with obstacles.²⁴

Vinter notes:

The worker is concerned with every point in the group's movement and participates actively to guide its process in desired directions. Similarly, he is also concerned with the group's organization and governing procedures it develops as well as the quality of interpersonal relationship amongst the members.²⁵

Hersey and Blanchard suggest:

The function of the leader was to facilitate cooperative goal attainment among his followers while providing opportunities for their personal growth and development.²⁶

A successful leader must contribute to both group objectives-goal achievement and group maintenance.²⁷

Vinter additionally suggests other specific tasks and functions for the group worker or leader. Among these are that: "he is the central person, the matrix of the group."²⁸; He "serves as the symbol and spokesman for the group, is the agent of legitimate norms and values."²⁹; He "is the motivator and stimulator; defines individual goals and tasks."³⁰; and finally, "he is the executive-the controller of membership roles."³¹

Bennis summarizes the attributes of a leader as follows:

the leader must be a conceptualist...more than an idea man, he must have a vision, a sense of perspective...he must have a sense of continuity...must know how to filter the unwieldy flow of information into coherent patterns...he must proceed toward the implementation (of goals) by designing a social architecture that encourages understanding, participation and ownership of the goals.³²

Delineating Process Goals and Strategies

Based upon the analysis and the review of the literature sources, both previously cited, it was possible to identify key process goals and strategies. These were delineated as follows: (1) to classify and define the role of the Research & Evaluation Council so that influencing the implementation process is given high priority; (2) to reinforce Council members identification with the Council and its activities; (3) encourage the active participation of Council members in assuming the responsibility for more task assignments; (4) where possible, provide rewards, e.g. public and professional recognition of their activities, for members; (5) increase communication between members and the Chairman between semi-annual meetings; (6) develop a system where the Chairman provides members with updated progress reports; and (7) establish a mechanism, e.g., conference calls, whereby

the Council could collectively agree to policy directions and task assignments at times other than the Council meetings. To fulfill these process tasks, it was recognized that the author had to serve as an active leader. This active leadership implied creating or utilizing the environment and/or the situation to maximize movement towards the goals cited above. It also implied maximizing the interpersonal relationships between the Chairperson and Council members.

Task-Strategies and Goals

Based upon the author's literature review, there were a number of factors that were considered in shaping task goals and strategies. These included (1) power and its importance and nature; (2) the relationship between the organization and its environment; (3) establishing legitimacy for an organization; (4) the role and functions of interest groups (5) developing a constituency; (6) developing an ideology; and (7) methods of task implementation.

(1) Power - Its Importance and Nature: Power is essential to bringing about change and in developing a program. There is a need to cognizant of its importance and its nature. This point is illustrated by several authors. Levin writes:

The fundamental concept in social science is power; in the same sense in which energy is the fundamental concept in physics. Power, like energy, has many forms...It is continually passing from one of its forms into any other.³³

Perrow observes that:

Power is the control of resources we think are essential to the functioning or survival of an individual or an organization.³⁴

Katz suggests that "limits to power are structured within the social systems."³⁵ Rein and Rabinovitz write "power involves bargaining between groups."³⁶ Finally, Salanick and Pfeffer indicate that:

political power far from being a dirty business is in its most naked form one of the few mechanisms available for aligning an organization with its own reality.³⁷

They conclude that "power derives from activities rather than individuals."³⁸

(2) An Organization and It's Environment: An organization is intermately connected to it's environment. This connection helps shape and focus the organization and it's tasks and activities. This relationship is pinpointed by numerous observers. Hirsch writes that "the environment effects an organization's strategies and tactics"³⁹ and that "one of the important tasks of an organization is to stabilize it's environment."⁴⁰ Kalizny and Veney note:

Since the organization is consistently interacting with it's environment, it is under increasing pressure to institutionalize environmental relationships and to guarantee support. Response to the latter pressure is often manifested as differentiation of activities which increases organizational complexity.⁴¹

Downs writes:

an organization needs to establish boundary areas...where there is an open heartland or vacuum, then a new or existing agency moves in.

Perrow suggests "part of the environment is the other organizations; a vast and complicated web."⁴³

(3) Establishing Legitimacy: Establishing legitimacy and an area of competency is essential for an organization. Downs notes:

an organization must demonstrate services are worthwhile.⁴⁴

an organization must create conditions that ensure the bureau's survival; it needs to develop an area of competency.⁴⁵

Perrow notes:

one of the implicit tasks of an organization is to establish the legitimacy of it's output and method of operation.⁴⁶

(4) The Role and Functioning of Interest Groups: One key aspect of developing strategies as related to tasks is to understand the role and functioning of an interest groups. On this subject, Powell writes:

A key aspect of the American system of public communications and shared power, the interest group makes it possible for individuals to make efficient use of their information and to give effective

voice to their attitudes and preference. In day to day actions, it is the interest group through which public opinion is a major felt influence on American bureaucracy.⁴⁷

(5) Developing a Constituency: It is essential for an interest group or an organization to establish a constituency base. This fact is specified by Downs as follows: "lack of a client group may doom an organization to failure."⁴⁸

(6) Developing an Ideology: Organizations need to develop an ideology.

This ideology Downs observes:

Creates an image..., it serves as a means of communication with constituents and government bodies...it is a way of influencing consumers...Ideologies emphasize positive action; it can help lead to the expansion of a bureau, protects it's territory and emphasizes it's social base.⁴⁹

(7) Methods for Implementing Tasks Strategies and Goals: In the development of task goals and strategies, we must give special consideration to the methods we will employ. Chairman Mao Tse Tung writes:

It is not enough to set tasks, we must also solve the problem of the methods for carrying them out. If our task is cross a river, we cannot cross it without a bridge or a boat. Unless the bridge or boat problem is solved, it is idle to speak of crossing the river. Unless the problem of methods is solved, talk about the task is useless.⁵⁰

Powell writes:

Methods used by interest groups to accomplish their goals are comparable to those used by any agency with substantial resources and aspirations attempting to influence others. The range of methods of persuasion extends over all the devices getting people to think, feel or act in some desired fashion. Major techniques include informal and formal consultation with bureaucrats, service on an agency advisory board, participation in public hearings, direct representation in the agency's bureaucracy, general lobbying activities directed at Congress and President, mass media and other publicity. The modern interest group is no secret organization represented by a man in an invisible cloak; it often openly seeks attention.⁵¹

Outlining Ultimate Task Goals

The task process involves several interconnecting links; (a) a

determination of ultimate goals and objectives; (b) delineating intermediate goals; and (c) developing strategies to obtain both intermediate and ultimate goals. Goal achievement, especially when we are discussing national program or policies, must be visualized as a "stepladder." Achievement of the ultimate goals, generally, occurs by climbing a step at a time. Although, we can fantasize about taking a "giant leap" to the top rung, we can also visualize the failures from the "giant leap"-damage to oneself or to others. Most significantly, the "giant leap" theory undercuts the "step" process which is of fundamental significance to a group or organization. It is through the process of taking limited strides that the group (organization) can develop in an orderly fashion, can stabilize it's environment, constructs a constituency base, gain legitimacy and, ultimately power and influence.

Given this framework, we can now turn our attention to the task goals and strategies for this project. As was noted earlier, it is indicated that effecting the implementation process at it's present stage involved: impacting on resource allocation; changing the attitudes and disposition of the implementors; improving and clarifying the communications process and impact on the enforcement process.

The ultimate task goals were envisioned in each of the four areas- (a) resource allocation; (b) attitudes and disposition of the implementors towards the policy; (d) the communication process; and (d) the oversight and enforcement process.

(A) Resource allocation includes the following:

1. Increase the total amount of funds available for technical assistance to the full 2% allowable under the CMHC Amendment of Public Law 94-63.
2. Increase the percent of the technical assistance funds to a

respectable level.

3. To develop a consistent high percent of technical assistance funds devoted to program evaluation by ADAMHA Regional Offices.
 4. To change the covert policy of NIMH and ADAMHA Regional Offices to permit CMHC's to be eligible to receive technical assistance funds to train and provide consultation services to other CMHC staffs.
 5. To develop a formal role for the Research & Evaluation Council in planning projects and suggesting resource allocation for NIMH Central Office sponsored projects in program evaluation and quality assurance.
 6. To develop a formal mechanism by which CMHC's can have input into ADAMHA Regional Office plans and resource allocation for technical assistance projects in program evaluation.
 7. To increase the number of NIMH and ADAMHA Regional Office staff who specialize in program evaluation activities.
- (B) Attitudes and disposition of implementors toward the policy includes:
1. To increase the general knowledge by NIMH and ADAMHA Regional Office staffs about program evaluation, it's importance to CMHC's and the political need to support evaluation to demonstrate the viability of CMHC programs to the legislative branch of government.
 2. To change the attitudes of ADAMHA Regional Office staffs towards the monitoring requirements associated with the program evaluation mandates. The attitude change involves assisting the Regional Office staff coming to visualize that monitoring functions can serve as a useful tool to CMHC program development.
- (C) Communication process indicate the following goals:
1. To improve the communication and coordination processes between

NIMH and ADAMHA Regional Offices to improve program planning and development in program evaluation.

2. To better inform CMHC's about the technical assistance projects in program evaluation that are being sponsored by the ADAMHA Regional Offices.

(D) Oversight and enforcement process task goals include:

1. To increase the clarity of the expectations of ADAMHA Regional Office staff of CMHC's as relates to program evaluation mandates for CMHC's.
2. To insure that ADAMHA Regional Office staff as part of the monitoring activities actually read and review CMHC Annual Evaluation Reports and Plans or to develop or fund a mechanism to insure that this activity occurs.

The Intermediate Goals:
Task and Strategies for the Project

It was recognized that given the limited (six month) time span of the project that attainment of most of the ultimate goals was beyond reach. However, delineation of these goals suggested directions for actions and strategies. Other major factors that effected actions and strategies were the tasks of consciously developing the Council on Research & Evaluation into an interest group (aside from the obvious interest group status of it's parent organization-NCCMHC), with a legitimacy, an ideology, a constituency, which were part of the task of interacting with the organizations environment. The ultimate goal of these activities was to develop sufficient power for the Council so that could move towards the achievement of the goals indicated previously.

Specifically, the tasks defined for the project were as follows:

(A) Organizational Development for the Research & Evaluation Council

1. Develop a direct linkage between the Council and CMHC program evaluators in order to establish a constituency and institute a feedback/communication loop through (a) publishing and disseminating a Research & Evaluation Council Newsletter; and (b) establishing Task Forces which would incorporate a broader group of CMHC evaluators in R&E program development.
2. To develop a closer working relationship between the Research & Evaluation Council and the National Council of Community Mental Health Center Board, staff, committees and Councils.
3. To develop a series of policy and positions on important issues on program evaluation to present to the Board of the National Council for their action.
4. To establish liaison with key professional associations of American Psychological Association, The National Association of Social Workers.

(B) Development of Organizational Relationships with the Central Office of the National Institute of Mental Health

1. To develop a formal liaison system with key branches of NIMH with which the Research and Evaluation Council did not have any previous contact. These branches included--The Survey and Report Branch of the Division of Biometry and Epidemiology; The Community Mental Health Services Support Branch; The Quality Assurance Program of the Mental Health Care and Service Financing Branch; and the Technical Assistance Committee of the Mental Health Services Development Branch, all of which are under the Division of Mental Health Service Programs and the Division of Manpower and Training.
2. To develop a system whereby the Research & Evaluation Council could have formal input into the development of 1% evaluation projects and 2% technical assistance programs sponsored by the NIMH Central Office.
3. To develop a formal method of communication with NIMH higher echelon

officials that would replace the informal methods of communication.

4. To develop a formal liaison relationship with the NIMH Central Office/ Regional Office Task Force on Program Evaluation in order to participate in planning program evaluation projects and in coordinating Central Office/ Regional Office activities on evaluation.

5. To develop a system whereby members of the Research & Evaluation Council would serve on advisory panels to contractors who were given funds by NIMH to conduct program evaluation studies or activities.

6. To encourage NIMH to adopt new procedures that would enable CMHC's to serve as providers for technical assistance training and consultation activities.

(D) Development of Organizational Relationships and Activities with the Ten ADAMHA Regional Offices

1. To acquaint the ten ADAMHA Regional Offices with the existence of the Research & Evaluation Council.

2. To emphasize to these ten ADAMHA Regional Offices the importance of program evaluation and the monitoring and technical assistance projects associated with evaluation.

3. To suggest and foster the idea that these ten ADAMHA Regional Offices help establish and fund Regional Evaluation Networks which would assist the Regional Offices in planning technical assistance projects in the area of program evaluation.

4. To suggest and foster the idea that these ten ADAMHA Regional Offices develop procedures that made it possible for CMHC's to qualify for funds to provide technical assistance training and consultation.

5. To suggest and foster the idea that these ten ADAMHA Regional Offices develop a mechanism whereby CMHC's receive feedback on their Annual Evaluation Reports and Plans which are submitted to meet the requirements under the Program Evaluation Guidelines.

It was these forementioned tasks that represented the goals for the project within it's limited time span.

Intended Operational Activities and Timetable

Based upon the goals that were established, it was possible to project certain activities and a time framework. It was recognized that it was not possible to project all activities or develop a timetable (outside of set meetings) with a huge degree of certainty. There were a substantial number of unknowns that it was realized would ultimately affect the project and the worker's activities. The following tentative outline was developed: January 1978-(1) Plan for the Research & Evaluation Council meeting in February. This included making contact with key NIMH officials and in developing R&E member input into the establishment of an agenda. (2) Arrange to be invited as a representative of the NCCMHC to the joint NIMH-NCCMHC meeting occurring in February.

February 1978-(1) Conduct the two day Research & Evaluation Council meeting. In conducting this meeting, establish new methods and procedures for R&E Council operations stressing increased member input. As part of the meeting, a goal was to establish liaison with NIMH branches and staff. Finally, it was determined to obtain R&E Council acceptance of a Newsletter and the idea of Task Forces. (2) To attend and participate in the NCCMHC meeting. In attending this meeting, the author's goal was to increase the recognition of the Research & Evaluation Council and to make contacts with CMHC evaluators, managers and board members. (3) To attend and participate in the NCCMHC Board Meeting. The goal in attending the Board Meeting was to establish contact with key board and staff members. (4) To attend and participate in the joint NIMH-NCCMHC Meeting. In attending these meetings, the goal was to establish contact with key NIMH Central Office staff and

ADAMHA Regional Office Chiefs and to stress the importance of evaluation. March/April 1978-These months were seen as being devoted to followup activities from the R&E Council Meeting and the joing NIMH-NCCMHC Meeting. It was hypothesized that these tasks would include: formal communications with NIMH and ADAMHA Regional Office staffs, drafting resolutions and position papers for the NCCMHC Board and developing a new communications system for the Research & Evaluation Council. In addition, it was thought that these months would also be devoted to drafting a Newsletter, establishing Task Forces and establishing relationships with other professional organizations.

May 1978-This month was seen as being devoted to the publication of the Newsletter and work on the Task Forces.

June 1978-This month was visualized as being devoted to attendance at the NCCMHC Board Meeting and preparatory work, and possible attendance, at an NIMH Regional Office/Central Office Task Force on Evaluation meeting.

CHAPTER IV

FOOTNOTES

¹Telephone interview with the Executive Director of the National Council of Community Mental Health Centers, October 17, 1977.

²Telephone interview with the Program Evaluation Specialist of the National Institute of Mental Health, October 17, 1977.

³ibid.

⁴ibid.

⁵ibid.

⁶David Gillespie, "Discovering and Describing Organization Goal Conflict," Administration in Social Work. Winter 1977, p. 397.

⁷Paul Hersey and Kenneth H. Blanchard, Management of Organizational Behavior: Utilizing Human Resources. (Englewood Cliffs, New Jersey: Prentice-Hall, 1972), p. 45.

⁸Robert Tannenbaum and Sheldon David, "Values, Man and Organizations," in Newton Margulies and Anthony Rais, (Eds.), Organization Development: Values, Process and Technology. (New York: McGraw-Hill, 1972), p. 23.

⁹Ralph M. Stogdill, "Dimensions of Organization Theory," in James D. Thompson, (Ed.), Approaches to Organizational Design. (Pittsburgh: University of Pittsburgh Press, 1971), p. 15.

¹⁰George Brager, "Goal Formation: An Organizational Prospective," in National Association of Social Workers, Social Work with Groups-1960. (New York: NASW, 1961), p. 23.

¹¹Jerald Hage and Michael Aiken, Social Change in Complex Organizations. (New York: Random House, 1970), p. 10.

¹²Stogdill, op.cit., p. 14.

¹³William Schwartz, "The Social Worker In The Group," in National Association of Social Workers, New Perspectives on Services to Groups-Theory, Organization and Practice. (New York: NASW, 1961), p. 18.

¹⁴Robert D. Vinter, "The Essential Component of Social Group Work Practice," School of Social Work-University of Michigan, 1959, (mimeo), p. 7.

¹⁵Stogdill, op.cit., p. 14.

¹⁶Hersey and Blanchard, op.cit., p. 159.

- ¹⁷David Shaw, "Size of Share in Task and Motivation in Work Groups," in Evan William (Ed.), Organizational Experiments-Laboratory and Field Research. (New York: Harper and Row, 1971), p. 63.
- ¹⁸Edwin P. Hollander, "Style, Structure and Setting in Organizational Leadership," Administrative Science Quarterly. March 1971, p. 3.
- ¹⁹Arnold Tannenbaum, Social Psychology of the Work Organization. (Belmont, Cal.: Brooks-Cole, 1966), p. 24.
- ²⁰ibid., p. 27.
- ²¹Lowenstein, etal, "The Management of Organizational Change: Some Findings and Suggestions," Public Welfare. Winter 1973, p. 50.
- ²²Bernard Bass and Harold Leavitt, "Experiments in Planning and Operating," in Evan William (Ed.), Organizational Experiments-Laboratory and Field Research. (New York: Harper and Tow, 1971), p. 71.
- ²³Louis R. Pondy, "Organizational Conflict, Concepts and Models," Organizational Development: Values, Process and Technology. Edited by Newton Margulies and Anthony P. Raia. (New York: McGraw-Hill, 1972), p. 279.
- ²⁴Schwartz, op.cit., p. 23.
- ²⁵Vinter, op,cit., p. 8.
- ²⁶Hersey and Blanchard, op.cit., p. 70.
- ²⁷ibid., p. 77.
- ²⁸Vinter, op.cit., p. 10.
- ²⁹ibid., p. 12.
- ³⁰ibid., p. 13.
- ³¹ibid., p. 14.
- ³²Warren Bennis, The Unconscious Conspiracy. (New York: American Management Association, 1976), p. 131-138.
- ³³Hannah Levin, "Power and Conflict-Key Components in Community Dynamics," Citizenry and The Hospital. (Durham, North Carolina: Department of Health Administration, 1974), p. 28.
- ³⁴Charles Perrow, Organizational Analysis: A Sociological View. (Belmont, Cal.: Brooks and Cole, 1970), p. 273.
- ³⁵Fred Katz, Autonomy and Organization. (New York: Random House, 1968), p. 62.
- ³⁶Rein and Rabinovitz, op.cit., p. 8.

³⁷Gerald R. Salanick and Jeffrey Pfeffer, "Who Gets Power and How They Hold On To It," Organizational Dynamics. Winter 1977, p. 4.

³⁸Ibid., p. 8.

³⁹Paul Hirsch, "Organizational Effectiveness-The Institutional Environment," Administrative Science Quarterly. September 1975, p. 44.

⁴⁰Ibid., p. 36.

⁴¹Arnold Kalizny and James Veney, "Service Implementation in Emergency Human Service Agencies: Individual, Organizational and Community Factors," in Journal of Social Service Research. Winter 1977, p. 165.

⁴²Anthony Downs, Inside Bureaucracy. (Boston: Little, Brown & Co., 1967), p. 106.

⁴³Perrow, op.cit., p. 33.

⁴⁴Downs, op.cit., p. 15.

⁴⁵Ibid., p. 16.

⁴⁶Perrow, op.cit., p. 25.

⁴⁷Norman J. Powell, Responsible Public Bureaucracy In The United States. (Boston: Allyn and Bacon, 1967), p. 118.

⁴⁸Downs, op.cit., p. 22.

⁴⁹Ibid., p. 125.

⁵⁰Mao Tse Tung, Quotations from Chairman Mao Tse Tung. (Peking, China: Foreign Language Press, 1976), p. 226.

⁵¹Powell, op.cit., p. 120.

CHAPTER V

DESCRIPTION OF ACTIVITIES

Process Activities

As was noted in the previous section, there were seven major process goals and activities that were delineated for the project. These were as follows: (1) to have Council members define influencing the implementation process as a high priority for the Research & Evaluation Council; (2) to reinforce members identification with the Council and it's activities; (3) encourage the active participation of Council members in assuming the responsibility for more task assignments; (4) where possible, provide rewards for members; (5) increase communication between Council members and the Chairman in the periods between semi-annual meetings; (6) develop a system where the Chairman provides members with updated progress reports; and (7) establish a mechanism whereby the Council could collectively decide on policy directions and task assignments at times other than the Council meetings.

Within these seven tasks, not all were assigned equal importance. Three process activities--redefining the role of the Council to give high priority to influence the implementation process, encouraging active participation of Council members in assuming increased task responsibilities and increasing members identification with the Council and it's activities--were considered of primary importance. The four other tasks and activities were considered of secondary importance.

Ideally, all the processes and tasks would have been preplanned with

intricate detail. Given the nature of the project, aside from several tasks dictated by prescheduled meetings, many tasks and processes occurred with a large degree of spontaneity. A number of the processes delineated occurred simultaneously while selected others developed in a sequential fashion.

The following description of the activities on a monthly basis is provided as an overview.

January 1978--The first month of the project focused primarily on activities associated with the February meeting of the Research & Evaluation Council. Planning and developing an agenda with a focus on implementation issues and providing for input of Council members in the development of that agenda were key tasks. Involvement of Council members in preparing the agendas was accomplished by first mailing draft agendas and then having individual followup telephone calls to discuss the topics for inclusion. Specific attention was paid to orienting a new member to the Council by providing him with detailed descriptions of the Council's history and activities. Further contact with the members occurred in relation to the issue of conducting a survey of CMHC evaluators at the Annual NCCMHC Program Meeting. Members input was solicited as to (1) agreement with sponsoring the project and (2) offering technical suggestions as to design and items.

February 1978--The main thrust of process activities focused on direct contact with Council members. This contact consisted of both formal meetings and informal social activities. The meetings consisted of hours of work spread over two days, during which time the R&E Council followed it's established agenda. The formal meetings were structured to allow substantial open discussion and group decision making. Members, as part of the decision making process, were encouraged to assume a variety of work tasks as followup activities. The informal activities included having lunches, dinner and

occasionally breakfast together. The emphasis was placed on group activities. Out of the following meeting emerged a series of followup tasks. Among these were the Chairman's preparation of a detailed report of the Council's activities and decisions, which was shared with the membership. Additionally, another important task involved action necessitated by the failure of one Council member--Dr. Robert Hayward--to attend meetings or to fulfill task assignments. This failure necessitated direct contact with Dr. Hayward and with the NCCMHC Executive Director to provide a warning over the lack of performance and develop the groundwork for Dr. Hayward's removal from the Council.

March 1978--Most of this month's activities focused on group maintenance. There were a minimum of at least one telephone contact with each Council member. The purposes of the individual contact was to focus on member's perceptions of the important issues and roles for the Council. It was a followup to a letter from Lucy Dowd and Margie Harper to the author, in which they raised the issue of future direction and concern over the priority given to liaison with NIMH staff. The author circulated the letter to Council members and had in-depth telephone conversations with each member. Based upon these discussions, it was evident that members felt (a) a need for increased communication between meetings (b) a need to focus on issues other than those strictly related to NIMH and (c) a sense that there was a need to broaden the areas of the Council's interests and directly reach out to CMHC's. In the course of individual conversations, arrangements were made with Council members to assume certain key tasks (which, in most cases, also represented rewards through their exposure to colleagues on a national level). Jeanne Kramer and Margie Harper were appointed to serve on an advisory group to a NIMH contractor who was studying national CMHC program evaluation activities. Margie Harper was asked, and agreed, to assume the role of

liaison to NIMH Division of Epidemiology. Jeanne Kramer assumed the role of liaison representative to NIMH Division of Biometry. It was arranged through the NCCMHC Executive Director for Jeanne Kramer to attend the National Conference on Mental Health Statistics as the National Council representative. In addition, the author had several contacts with Mervin Newton* to discuss his areas of interest.

April 1978--Updated progress reports were sent to Council members, the NCCMHC Executive Director and the NCCMHC President. Dr. Hayward called to indicate he could not fill time commitments to the Council and was resigning. Council members were informed in writing about the resignation, were asked to submit possible nominees for the vacancy and informed that the procedure for selecting a replacement would involve their rank order assessments of the candidates. There were a number of telephone contacts with Council members to receive progress reports on their activities. Based upon these telephone conversations, it seemed apparent that a conference call between members would be useful. The author scheduled the conference call and made the fiscal arrangement with the National Council. With all Council members on the line, the conference call lasted over one and one-half hours. During the call, the Council members discussed progress on a number of issues and future directions for the Council. In this conversation, Mervin Newton, who previously was hesitant to offer suggestions, made numerous comments and freely offered ideas.

May 1978--Many of the activities during the month focused on obtaining a replacement for Dr. Hayward. As Chairman, the author had telephone conversations with twelve individuals whose names were submitted for consideration for the vacancy. In the conversations with these professionals, the work of the Council and expectations of Council members was discussed. Ballots were sent to Council members who rank ordered their preferences. The
*fictitious name

Chairman tabulated the results. The tabulation revealed a three-way tie. This issue was then discussed in depth with the NCCMHC Executive Director and with the Council members. Based upon this discussion, it was decided to recommend (to the NCCMHC President) the appointment of the nominee from the geographic area that was not represented on the Council. This was Charles Willard*, Region I. During this time, the Chairman also had conversations with several Council members on task related topics. Several conversations were held with Dr. Kramer, who was quite anxious about the preparation of written materials for her activities as liaison to the NIMH Office of Biometry. Her anxiety was greatly relieved by asking Dr. Fred James*, a CMHC evaluator with experience in Biometry issues, to provide her with informal consultation. The author also, in great detail, discussed the National Conference on Mental Health Statistics and Dr. Kramer's role. Lucy Dowd was also contacted and worked in assisting in the development of an instrument for a national survey of CMHC evaluators. It should also be noted that the author involved Council members in reviewing drafts of the R&E Council Newsletter in order to get their ideas and to also have them feel that the publication represented the Council and not just it's Chairman.

June 1978--This last month of the time period covered by the project (but not of the Chairman's involvement with the Council) encompassed several group maintenance related activities. These included finalizing Charles Willard's appointment to the Council through discussion with the President of the NCCMHC, issuing an updated progress report on the Council activities, working with Lucy Dowd, Margie Harper and Jeanne Kramer on a number of task related topics and rectifying a disagreement between Margie Harper and the author in relation to a report on the ADAMHA Regional Office Technical Assistance Activities and the procedures utilized for Council members involvement in reviewing the report.

*fictitious name

Task Activities

The task goals for the project were based upon concern with several factors--power, environmental factors, the need to establish for the Council a legitimacy, a constituency, and an ideology to fulfill the role of an interest group. The goals were delineated as follows: (1) Organizational Development of the Research & Evaluation Council (a) linkage with CMHC evaluators through development of a Newsletter and a series of Task Forces; (b) developing close relationships with the National Council Board and staff; (c) develop a series of policy and position papers on program evaluation for consideration by the National Council Board; (d) establish liaison with other professional groups, e.g., the American Psychological Association and the National Association of Social Workers (2) Develop Organizational Relationships with NIMH Central Offices (a) establish formal liaison with the following NIMH branches--Division of Biometry and Epidemiology, the Quality Assurance Program and the Technical Assistance Committee (b) develop a system of formal R&E Council input into 1% Evaluation projects and 2% Technical Assistance programs; (c) establish a formal method of communication with NIMH higher echelon officials; (d) to develop a formal liaison with the Central Office/Regional Office Task Force on Program Evaluation; (e) develop a system whereby R&E Council members would serve on advisory panels to NIMH contractors doing program evaluation related studies; (f) encourage NIMH to adopt new procedures to enable CMHC's to serve as technical assistance contractors (3) Development of Organizational Relationships with the Ten ADAMHA Regional Offices (a) to acquaint the ten ADAMHA Regional Offices with the R&E Council; (b) to emphasize to these Regional Offices the importance of program evaluation and technical assistance activities; (c) to suggest the establishment and funding of Regional Office Evaluation Networks; (d) to foster the idea that ADAMHA Regional Offices

help fund CMHC's to provide technical assistance; and (e) to foster the idea that the ADAMHA Regional Offices develop mechanisms whereby CMHC's receive feedback on the Annual Evaluation Reports and Plans.

These task activities are described in this month-by-month overview.

January 1978--A major thrust of activities for the initial month involved contacting various branches of NIMH and arranging for their participation in the February R&E Council meeting. Arrangements were made for the participation of the Chief of the Office of Program Evaluation, the Program Evaluation Specialist-Division of Mental Health Service Programs, and a representative of the Division of Biometry. The Chief of the Office of Program Evaluation and the Program Evaluation Specialist had participated in previous meetings while the representative from the Division of Biometry had not. A second task involved the preparation of specific recommendations on program evaluation requirements for the CMHC renewal legislation for presentation to the February meeting of the Public Policy Committee of the National Council. The third major activity was the development of a questionnaire on CMHC Program Evaluation which was intended to be utilized at the NCCMHC Annual Meeting in February. The survey was going to be jointly sponsored by the R&E Council and the Philadelphia Health Management Corporation, which had a NIMH contract to study program evaluation in Centers. The concept of the study, which was intended to serve an important purpose for both the Council and the contractor, was to gather data from large numbers of CMHC evaluators. Preparation of the survey involved contact with the contractor, NIMH officials and R&E Council members.

February 1978--This, the second month of the project, involved task accomplishment through meetings. The first of these meetings was one in which the R&E Council presented its recommendations on the program evaluation requirements for the CMHC renewal legislation to the NCCMHC Public Policy

Committee. In this presentation, we discussed the recommendations that had been prepared in writing and submitted to the Committee the previous month.

This was then followed by the two day R&E Council meeting. During the course of the meeting, the following actions occurred: (1) The report of the Task Force on Quality Assurance was approved and sent on to the NCCMHC Board; (2) In discussions with the representative of NIMH Division of Biometry, numerous ideas were exchanged, and it was agreed to establish formal liaison; (3) With the Chief of the Office of Program Evaluation, the Council discussed a variety of issues including the 1% Evaluation projects that NIMH was planning to sponsor during Fiscal Year 1979 (to which Council members offered specific suggestions); (4) We discussed numerous ideas for 2% Technical Assistance projects with the Program Evaluation Specialist. Among the ideas proposed was the establishment of a Clearinghouse on Program Evaluation in CMHC's; (5) In the course of discussions with these NIMH representatives, they agreed that the R&E Council should be represented on an advisory board to NIMH contractors conducting program evaluation studies; (6) The Program Evaluation Specialist agreed to the suggestion that the R&E Council attend the meetings of Regional Office/Central Office Task Force on Program Evaluation; (7) The Council agreed with the idea of establishing an R&E Council Newsletter.

One and one-half days of NCCMHC Board meetings followed the R&E Council meeting. Since this was only the second meeting of the Board that the author attended, he devoted a substantial amount of time to making informal contacts with Board members and NCCMHC staff. The author made a formal presentation to the Board in which the author outlined the R&E Council discussions and requested adoption of the Task Force Report on Quality Assurance. The Task Force Report and its specific recommendations

were approved by the Board.

Immediately following the Board meeting, the author attended the three and one-half days of the National Council Annual Program Meeting. During this time, numerous contacts were made by the author with CMHC evaluators, Board members and administrators. In these informal contacts, the R&E Council and its activities were discussed. The author also had the opportunity to briefly present an overview of the R&E Council activities to large groupings of CMHC staffs and Boards through two formal presentations.

The last of the meetings, which immediately followed those that were described, was a two-day activity involving representatives of the NCCMHC and of NIMH Central Office and ADAMHA Regional Offices. The purpose of this meeting was to promote an exchange of ideas between the three parties. During the meetings, the author had the opportunity to make informal contacts with NIMH Central Office staff and ADAMHA Regional Office chiefs. In these informal conversations, the author described the R&E Council and its activities. In the course of discussions following formal presentations, the author emphasized the importance of program evaluation and the essential role of the NIMH Central Office and the ADAMHA Regional Offices in promoting its development.

Following these meetings, the author had numerous followup tasks including writing a progress report for the Board and the Council and drafting letters for the National Council Executive Director to send to NIMH officials.

March 1978--The third month of the project was marked by involvement in a number of projects and activities. These included: (a) arranging for Dr.'s Kramer and Harper to be appointed by the NIMH Program Evaluation Specialist to the advisory group to the Philadelphia Mental Health Management Corporation (a contractor receiving NIMH funds to study program evaluation

in CMHC's); (b) arranged with Margie Harper to serve as liaison to NIMH Division of Epidemiology; (c) arranged with Jeanne Kramer to serve as liaison to NIMH Division of Biometry; (d) after a telephone conversation with the National Council Executive Director, the author arranged for Jeanne Kramer to represent the National Council at the National Conference on Mental Health Statistics; (e) the author conceived of the idea to study the technical assistance activities of the ADAMHA Regional Offices, drafted an outline of the project and the questionnaire, which was then shared with R&E Council members and the NCCMHC staff. The survey instrument was finalized by the end of the month and sent out to the ten ADAMHA Regional Offices; (f) the author attended a meeting sponsored by Division 27 of the American Psychological Association and the Department of Community Medicine of the State University of New York at Buffalo. The purpose of the meeting, held in Buffalo, was to discuss a large scale study of program evaluation in CMHC's. Attenders included three staff members from SUNY-Buffalo, the Chairman of APA-Division 27, a CMHC Director from the South, a health evaluation expert from a School of Medicine, the Program Evaluation Specialist at NIMH, a Quality Assurance Specialist at NIMH and the R&E Council Chairman. Although the participants had somewhat different interests and priorities, it was agreed to have a three-way sponsored survey--APA, SUNY-Buffalo and NCCMHC--that NIMH might possibly help fund. Followup task assignments were made at the meeting; (g) the author drafted his questions for the CMHC Program Evaluation study and sent them out to meeting participants; (h) formal contact was established with a consultation firm from the Midwest on the issue of evaluating CMHC Consultation & Education proposals. This liaison led the author, as an individual, to review this firm's proposal to NIMH to develop technology in the evaluation of consultation and education programs and wrote a letter supporting the request.

April 1978--In this, the fourth month of the project, a number of tasks dominated: the provision of consultation and assistance to NCCMHC staff, continuation of activities on the CMHC Program Evaluation Survey, initiated work for the development of an R&E Council Task Force on Manpower & Training and a followup on associated tasks with NIMH.

The assistance provided to National Council staff included drafting a response for the National Council Executive Director on a NIMH sponsored report on Citizen Participation for the Evaluation and Review of CMHC's, providing the new legislative director with selected studies on the effectiveness of CMHC services, and suggesting to the Annual Program Committee and NCCMHC staff that Council's hold meetings open for attendees as part of the Annual NCCMHC Program Meeting.

Activities on the CMHC Program Evaluation Survey included continuing drafts of the questionnaire, discussions with staff from SUNY-Buffalo and with the NIMH Chief of Quality Assurance. The NIMH Quality Assurance Specialist was especially concerned since he felt that, aside from NCCMHC, the two other sponsors were not interested in the topic of quality assurance.

Work toward the establishment of a R&E Council Task Force on Manpower & Training included contact with the Director of the NIMH Division of Manpower & Training regarding the possibility of NIMH funding, discussions with Dr. Fred James and the NIMH Program Evaluation Specialist on the project, and with members of the R&E Council. This led to preparing a brief draft on the role and function of the Task Force.

Followup tasks with NIMH included reviewing material from the Director of NIMH Division of Mental Health Service Programs and contact with the Program Evaluation Specialist on a number of Council suggestions for technical assistance projects.

May 1978--In this month, the author was actively involved with numerous

types of tasks.

The most important task was work on the Research & Evaluation Council Newsletter. This included drafting the Newsletter, sharing the draft with R&E Council members, NCCMHC staff and with the Board Committee on Publications, reviewing their comments and finalizing the draft, finding out about funding and publication procedures and obtaining mailing labels from NIMH.

The next most important activity involved drafting the report on the survey of the ADAMHA Regional Office Technical Assistance on Program Evaluation. This included collecting the data from the Regional Offices, checking the accuracy of the data with key CMHC staff in the region, tabulating the data, drafting the report and sharing the report with NCCMHC staff and R&E Council members. Then, based upon suggestions from the NCCMHC Executive Director, the draft reports were sent to the Regional Office Chiefs for their review and comment.

Continuing work with the NCCMHC staff was also an important activity and involved providing the legislative director with data on Medicare, Medicaid and psychiatric service utilization and suggestions on the CMHC renewal legislation, providing more suggestions for the Annual Program Meeting, and drafting the NCCMHC response to HEW Regulations on the Protection of Human Subjects for Research Projects Who Reside in Mental Health Facilities. These activities were crucial in developing the relationship between the author and the NCCMHC staff.

Other activities included: (a) extensive work on Biometry issues-- reviewing and commenting on the Draft Report of Ad Hoc NIMH Committee to Review Information on Management Information Systems, and discussing issues with Jeanne Kramer on her role as liaison to NIMH Division of Biometry; (b) completing a re-draft of the outline for the Task Force on Manpower & Training; (c) contact with the NCCMHC Committee on Standards and Accreditation

to discuss differing positions on the JCAH Standards for CMHC's; (d) further contact with the Program Evaluation Specialist on the technical assistance suggestions of the Council; and (e) contact with the NIMH Quality Assurance Specialist in relation to the issue of the inclusion of quality assurance questions in the CMHC Program Evaluation Survey.

June 1978--The last month of the project witnessed the culmination of a number of activities, a continuation of others and even the development of some unexpected tasks.

The tasks that reached completion included (1) the mailing of the first R&E Council Newsletter (after approval by the NCCMHC Board Committee on Publications) to CMHC's and (2) the re-drafting of the Report for the ADAMHA Regional Office Technical Assistance Activities on Program Evaluation and its submission to the NCCMHC Board and its being sent to NIMH officials.

The new task developed in relation to the quality assurance information that was going to be collected as part of the CMHC Program Evaluation Survey. The Chief of Quality Assurance from NIMH called early in the month with the news that the representatives of SUNY-Buffalo had decided, despite the availability of limited NIMH funding, the survey would exclude all questions on quality assurance. The NIMH representative was desperate. He wondered how the NCCMHC could assist him and indicated a willingness to allocate funds for our assistance. After discussion, it was agreed that the NCCMHC would conduct a separate study of CMHC quality assurance activities. This was only the initial step. It was followed by a substantial amount of detail work--drafting the tasks for the project, establishing deadlines and budgets. Close liaison with the Executive Director and other staff at NCCMHC was necessary for this work.

A second new development was the invitation to attend a meeting of the NIMH Regional Office/Central Office Task Force on Program Evaluation

in Washington. By being present at the meeting, the author became an active discussant on several proposals, reported on the R&E Council activities, offered suggestions and established relationships with some ADAMHA Regional Office staff.

Continuing activities included (1) attending the two days of the NCCMHC Board meeting and strengthening ties with Board members and reporting on R&E Council activities (2) providing the NCCMHC Legislative Director with information on technical assistance for his meetings with NIMH staff (3) meeting with staff from the Urban Institute, at the request of the NCCMHC Legislative Director, to discuss the area of mental health outcome evaluation studies (4) meeting with a representative of NIMH Division of Biometry to discuss increasing the possibility of CMHC's bidding on NIMH Biometry contracts (5) further contact with representatives of SUNY-Buffalo on the CMHC Program Evaluation Survey and (6) followup with the Chief of NIMH Office of Program Evaluation on 1% evaluation projects.

CHAPTER VI

EVALUATION

An Overview

Evaluating a project of this nature represented a difficult problem since it encompassed varied goals and activities in both the task and process spheres. Moreover, given the scope and complexity of goals and the type of project activities, "hard" data was not readily available. Rather, it became necessary to employ an evaluation process that utilized surrogate measures. Moreover, to increase the validity of the evaluation design, stress was placed on developing a system that provided information from a number of different sources and from different perspectives. It should be noted that the author was aware from the inception of the project that it would be impossible for an evaluation to provide summative data. This difficulty was a direct result from the fact that the project was not a classic close ended activity (with a beginning and end) but instead represented an attempt to influence (in specific directions) an ongoing activity during a limited time period. Thus, the evaluation represented an effort to (1) provide descriptive quantitative data on project activities; (2) ascertain and quantify data from key "actors" associated with the project on it's achievement or impact or the lacks of goal attainment; and (3) measure the progresses or failures of the project against pre-established goals.

The components of the evaluation included: (a) design and establishing a project data system which enabled the author to describe and

delineate, in great detail, the activities associated with the project; (b) utilizing a series of questionnaires to ascertain perceptions from key actors or informants; and (c) a review, by the author, of project achievements based upon pre-set goals. Each of these components is discussed below.

The Project Data Collection System consisted of three subcomponents:

1. A Daily Log in which the author recorded all project activities. Each activity was recorded with the date, the type and purpose(s) of the activity, the individual or individuals contacted or involved in the activity and the time (estimated) spent on the activity.
2. A file of all correspondence sent and received by topic area.
3. A file of all reports and publications. The data gathered through these subcomponents enabled the student to describe and analyze his activities on the project, (e.g., time of activity, month, task, contact group) and provided documentation to measure achievement of goals and objectives. (Data from this system is described in later sections of this chapter.)

Questionnaires. The second major evaluative tool consisted of three sets of questionnaires. One set of questionnaires was utilized to obtain the perceptions of members of the Research & Evaluation Council on the project and its effect. The instrument, which was the most comprehensive of the three employed, consisted of questions on:

- the goals of the R&E Council and any changes over the duration of the project and agreement or disagreement with the emerging goals;
- the degree of the members participation in the project and changes, if any, over the six months of the project;
- the communication and decision making processes of the Council, their changes during the project and a value judgment as to their effectiveness;

-the members identification with and rewards received from the Council and changes in the rewards and identification over the six month project period;

-judgment as to the effectiveness of the Council's performance over the six month project period, and citation of specific successes and failures. It should be noted that the instrument was primarily designed to measure achievement in relation to the process goals delineated for the project.

The second instrument consisted of a one-page series of questions sent to the staff of the National Council of CMHC's. The questions requested ratings of the R&E Council as relates to NCCMHC goals and citation of the R&E Council major achievements during the six month project period. The questionnaire also requested suggestions for additional ways that the R&E Council could assist the National Council.

The last instrument was sent to selected NIMH Central Office staff (selection based upon their having a role in program evaluation activities and having been in contact with the R&E Council) and selected ADAMHA Branch Office Chiefs. The questions asked for their perceptions of the impact of R&E Council activities during the six month project on program evaluation activities sponsored by the NIMH Central Office and by the ADAMHA Regional Offices. The instrument also inquired as to the benefit and detriments of R&E Council activities to them in their official capacities and requested suggestions for the R&E Council to improve it's effectiveness and impact.

The three sets of questionnaires were mailed out in July 1978 immediately following the end of the project period.

The Author's Review of Goal Attainment

Based upon the pre-established goals, especially as related to tasks, the author reviewed goal achievement. This review was based upon documentation contained in correspondence files and reports and upon the author's

knowledge of events. This review, which started approximately two months after the end of the project, includes information obtained until October 30, 1978 or the time of the writing of this chapter. The fact that four months have passed since the end of the project has meant that a number of initiatives started during the project have come to fruition. Thus, the review permits longer range judgment than would have been available immediately after the project ended.

Results of the Evaluation

An Analysis of Time Spent on Project Activities

1. Total Time Spent: A total of 225 hours or 28.1 eight-hour work days were spent on project activities. This includes only task and project activities during the six month project. It excludes planning activities prior to January 1, 1978, the project start-up date, and evaluative or reporting activities post June 30, 1978, the end date of the project.
2. Time Spent by Month:

TABLE 1.--Time Spent by Month

	Hours	
Total Time Spent	225.00	100%
January	8.25	4%
February	68.00	30%
March	29.75	13%
April	27.50	12%
May	45.50	20%
June	46.00	21%

There was, as noted in the table above, substantial variation in the time spent on project activities by month. The project started slowly in January, escalated markedly in February (a partial result of numerous meetings), dropped in March and maintained the same rate for April, and then escalated in May and remained at a similar rate for June. The May and June rates, at higher levels, were a result of meetings and the need

to finish selected reports. The data does indicate the substantial amount of time required for a project of this nature. This finding does suggest that involvement in a project of this type requires a pre-existing organizational requirement that would enable the project leader to make this type of substantial time investment.

3. Time Spent By Source of Interaction (By Month)

TABLE 2.--Time Spent By Source of Interaction

Source of Interaction	Total Hours	% of Total Hrs	Jan.	Feb.	March	Apr.	May	June
	225.00	100%	8.25	68.0	29.75	27.5	45.50	46.0
Solo Acts - No Interaction	46.0	20%	2	7	7	5.75	16.75	7.5
Interaction with R&E Council members	46.50	21%	3	16	8.5	5.5	8.25	5.25
Interaction with NCCMHC staff members	18.0	8%	-	4	1	3	5.75	4.25
Interaction with NCCMHC Board members	23.75	11%	1	8	.25	.5	3	11
Interaction with NIMH Central Office staff	37.0	16%	1.5	16.5	2	7	7.5	2.5
Interaction with ADAMHA Regional Office staff	22.0	10%	-	10.5	2	1.5	1.25	6.75
Interaction with Others (Other Professional Organizations)	31.75	14%	.75	6	9	4.25	3	8.75

The table and charts which follow demonstrates the varied nature of project activities.

Approximately 20% of the author's time was spent in solo acts with no interaction with other parties. These solo activities generally consisted

of writing activities. These writing activities included preparing the R&E Council progress reports, preparing reports on the results of studies, drafting and finalizing instruments, preparing the R&E Council Newsletter and maintaining correspondence. The table indicates an especially high total for May. This was primarily due to preparing the R&E Council Newsletter and drafting the Report on the Survey of ADAMHA Regional Offices.

-Interaction with Research & Evaluation Council members represents that activity in which the author spent the most time (approximately 21% of all the time spent on the project). Aside from the two-day meeting in February and the conference call in March, most of the time spent was in telephone contact with individual Council members. As was noted in a previous chapter, these contacts generally involved both task and process activities.

-Interaction with National Council staff members was the least time-consuming of all activities. It only represented 8% of all time spent on the project. These interactions generally involved exchanges of information and requests for assistance.

-Interaction with National Council Board members represented 11% of all time spent. In this category, there was great variation by month. Most of the interactions occurred at the February and June Board meetings.

-Interaction with NIMH Central Office staff represented 16% of all of the time spent on the project. The time spent varied with February as a result of joint meetings being the highest. In general, interactions were task oriented and involved work on specific projects.

-Interaction with ADAMHA Regional Office staff represented 10% of all the time spent on project activities. With the exception of February and June, contact with ADAMHA Regional Office staff was very limited. In

February, there was substantial contact as a result of the two-day NCCMHC-NIMH-ADAMHA meetings. In June, contact with Regional Office staff rose as a direct result of the author's participation in the NIMH Task Force on Program Evaluation meeting and through work on the Survey of ADAMHA Regional Offices. In general, aside from task activities related to the forementioned survey, most of the contact was devoted to establishing liaison and providing them with information on the R&E Council and program evaluation.

-The category of interaction with others is a "catchall." It represents contact with a range of other individuals and organizations. In the main, these include other mental health professionals, academicians, representatives of contractors or consulting firms and government officials other than those from NIMH. These contacts represent 14% of all time spent. It was heaviest in March as a result of a meeting at State University of New York at Buffalo and in June as a result of recruitment and report activities.

These results are highlighted in Figures 4, 5, 6 and 7, which follow.

FIGURE 4
PROJECT HOURS BY MONTH

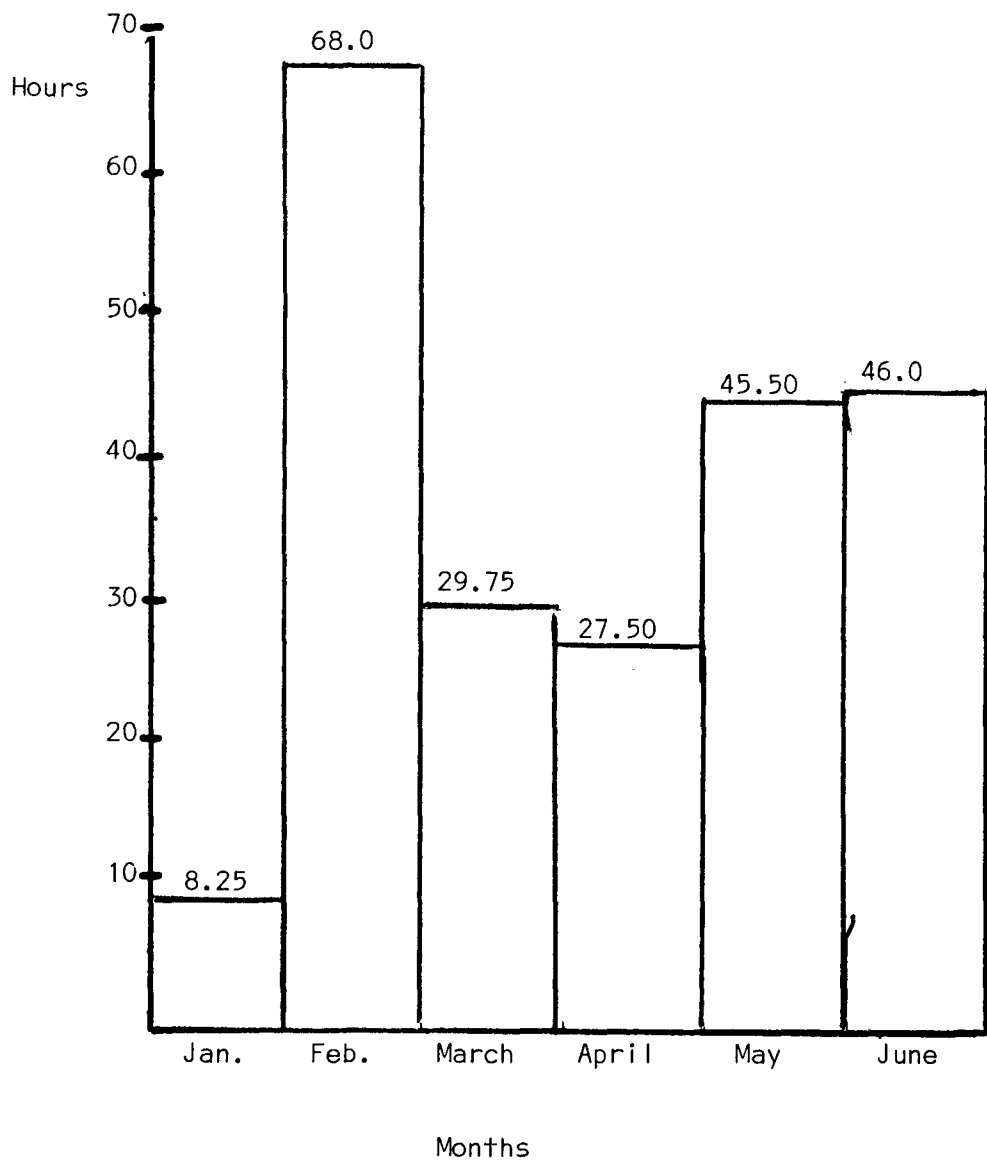


FIGURE 5

TIME SPENT BY CATEGORY OF INTERACTIONS

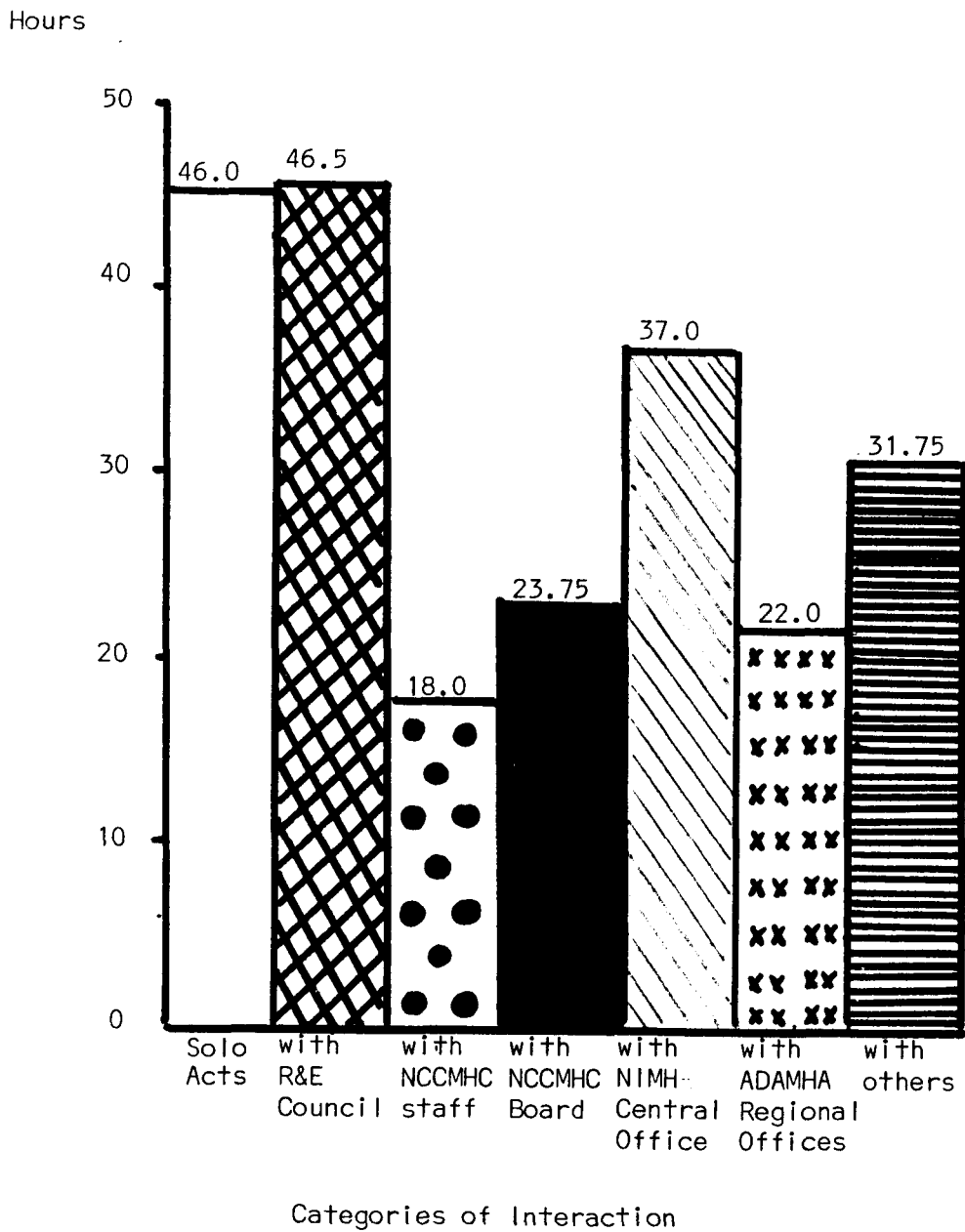


FIGURE 6
TIME SPENT BY INTERACTION

CATEGORY BY MONTH

Legend
 J=January
 F=February
 M=March
 A=April
 Ma=May
 Ju=June

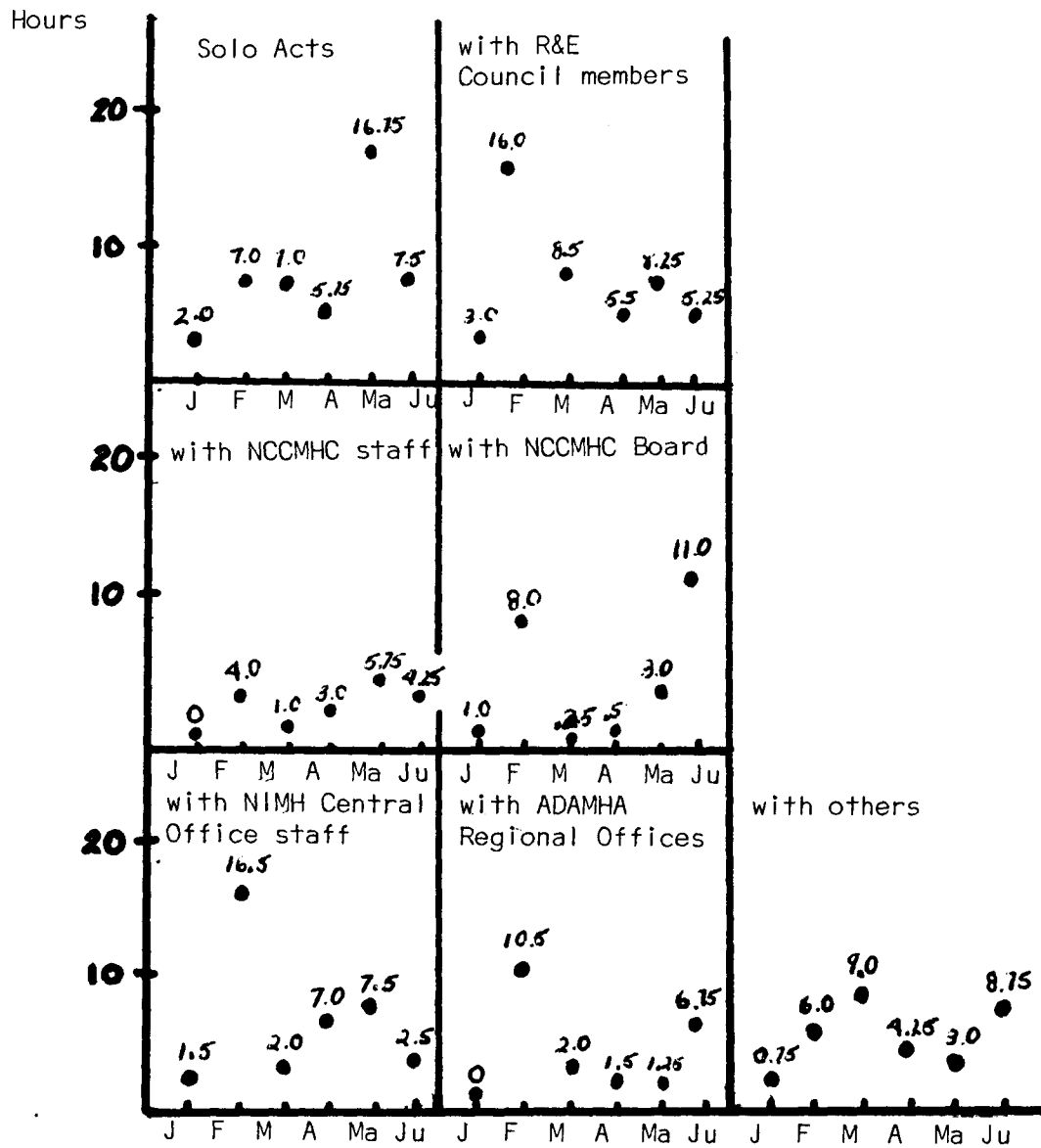
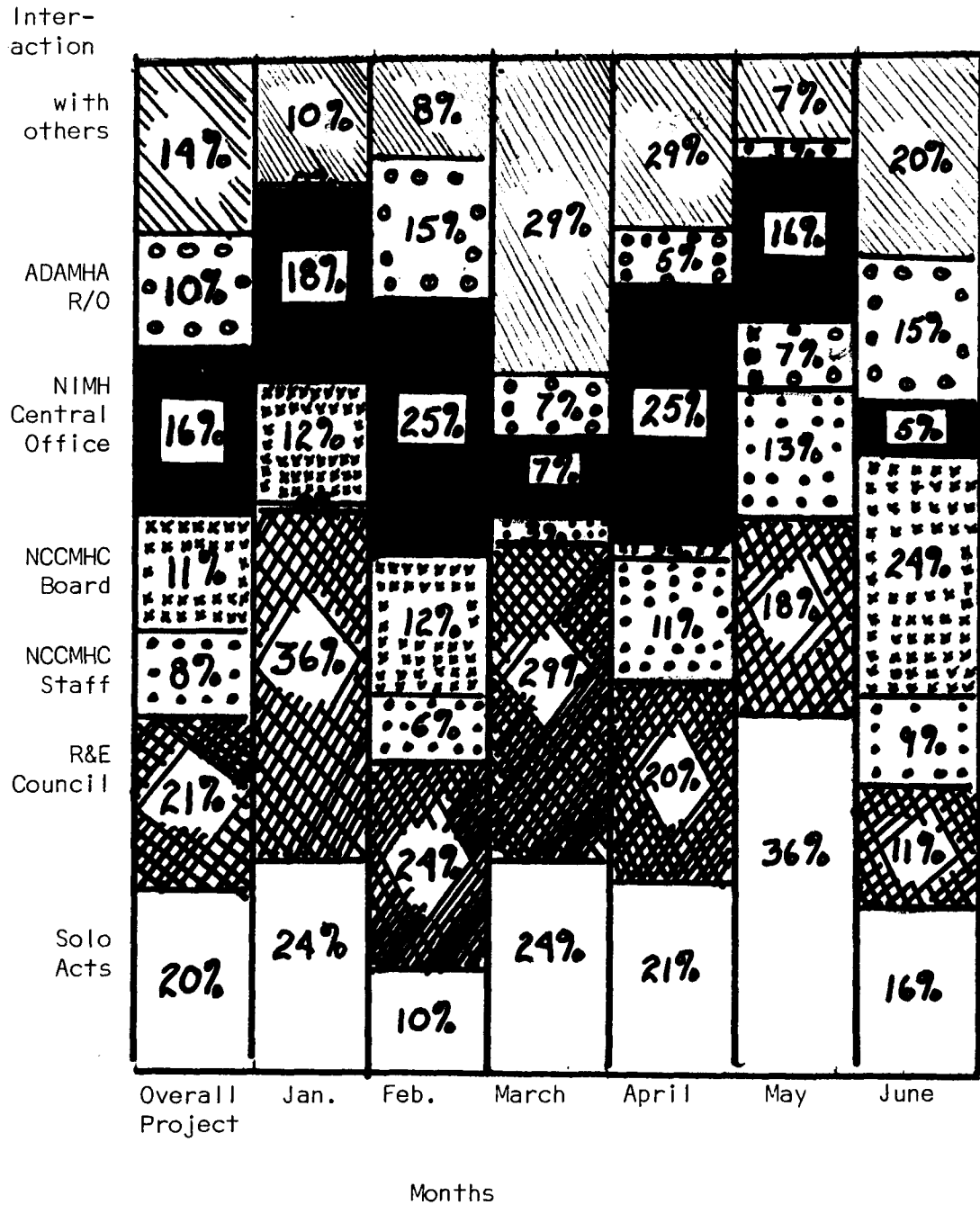


FIGURE 7
 TIME SPENT BY INTERACTION
 CATEGORY BY MONTH
 (PERCENTS)



Response to Survey Instruments

1. Survey of Research & Evaluation Council Members: The survey form was completed by three R&E Council members. The members completing the surveys were Jeanne Kramer, Lucy Dowd and Margie Harper. Mervin Newton did not complete a form and indicated that since he had only recently joined the Council, he felt he was not sufficiently knowledgeable to complete the survey. There was no fifth member to complete this survey since Dr. Robert Hayward had resigned from the Council. Thus, the universe for this survey was only three. However, the data which was provided was quite revealing.

The data provided the following information:

-As relates to defining the major goals for the R&E Council, only two were uniformly agreed to by all three respondents. These two were "providing advice and guidance to National Council staff and Board and influencing NIMH staff and activities." Two of the three defined "serving as advocates and providing aid to CMHC's" as a major goal. Other major goals noted were "influencing JCAH standards" and "changing data reporting requirements for Centers." Two of the three respondents felt that the goals had changed during the six month project time. The changes cited were "the Council is developing a more active rather than maintaining a passive role" and "using research data for advocacy for CMHC's." All three respondents indicated general agreement with the goals of the Council although one member (Dr. Harper) indicated she felt some uncomfortableness with the Council serving as an advocate for Centers.

-In response to reviewing their participation during the six month period, two respondents felt their participation had changed. Of these two, one felt their participation had increased while the other felt her's had slightly decreased. Two members considered themselves active participants of the Council and devoted from four to six hours per month to it's

activities. One member rated herself as a very active participant and indicated she spent up to twenty hours per month on Council activities.

-As relates to the communication process within the Council, all three respondents noted a change in the past six months. The change noted was an increase in communications, and they cited the conference call, increased reports and between-meeting telephone contacts. In rating the present communication system, one member rated it as very good, another as good and a third as fair.

-As relates to the decision making process in the Council, one member noted a change and the other two did not. The change noted was "the eagerness of the Chairman to carry out a wider range of activities." All three felt they were active participants in the decision making process and felt that the process was good.

-The questions on identification with the R&E Council and rewards from participation revealed interesting opinions. Two of the members indicated they felt a strong identification with the Council and its work. The third respondent indicated some identification. The members who felt strong identification with the Council both noted pride in work done by the Council, and their thinking of the Council and its position when asked to provide opinions on key issues. The rewards of membership were seen as varied and multiple. All three cited the opportunity to relate to others in the field as an important reward. Other rewards cited included "recognition and status", "the opportunity to obtain information on the national scene", and "a learning experience."

-As to rating the R&E Council's overall effectiveness, two indicated that it was effective and one did not respond. The major achievements of the Council were seen as "its impact on the utilization of NIMH Technical Assistance funding for CMHC program evaluation activities" (three members),

"it's work on the JCAH Standards" (pre-project) (two members), "the work on Quality Assurance (pre- and during project) (two members), "the survey of the ADAMHA Regional Offices" (two members), "having R&E Council members serve on advisory committees to NIMH contractors" (one member), and "increasing federal responsibilities in the area of program evaluation" (one member). The failures or problems with the Council cited were "lack of followup in relation to a recommendation to NIMH to sponsor an audio visual project to develop program evaluation training materials" (one member); (It should be noted that this being cited as a failure actually represents a failure in communication. NIMH has, actually, approved and funded a pilot project in this area as a result of R&E Council recommendations.); "lack of work on the issue of confidentiality in research activities" (one member); "the lack of response to the R&E Council's report on JCAH Standards" (one member), and one comment that "the Council needs to slow down and focus it's attention."

2. Survey of National Council of Community Mental Health Centers Staff: A brief one page questionnaire was sent to the NCCMHC professional staff members. All three of the professional staff, (the Executive Director, the Legislative Director, and the Director of Training) responded. The data showed the following:

-Two of the three respondents rated the performance of the R&E Council during the six month project period as very effective, and the third gave a rating of effective.

-The major achievements cited were active involvement with NIMH on a wide range of issues (all three noted this), developing a plan to assist CMHC's (two respondents), initiating the R&E Council Newsletter (two respondents), assessment of the JCAH Standards (one respondent), and the

Quality Assurance Task Force activities (one respondent).

-Suggestions for future activities included increasing and strengthening the relationship between the R&E Council and CMHC staffs, work with NIMH to improve statistical reporting, and support the development of better techniques for evaluation activities, (e.g., outcome studies).

Based upon this information, even though it is limited, it seems apparent that in the opinion of NCCMHC professional staff, R&E Council operations were visualized as highly effective, and that in relation to the pre-set project goals of impacting on program evaluation implementation and increasing communication with CMHC's, the NCCMHC views the R&E Council as having made major achievements.

3. Survey of NIMH Central Office Staff and ADAMHA Regional Branch Chiefs: Surveys were mailed to key NIMH Central staff who had working relationships with the R&E Council. The instruments were mailed to three officials--the Director of Mental Health Services Programs, the Acting Chief-Program Analysis and Evaluation Branch, and the Program Evaluation Specialist. In addition, surveys were mailed to four of the ten ADAMHA Regional Office Branch Chiefs. The Regional Offices to which the survey was mailed were Regions II, V, VII and X.

The response rate varied. All three of the NIMH Central Office staff responded but only two of the four ADAMHA Regional Offices responded. Furthermore, one of the two responses from the ADAMHA offices was prepared by a staff member, who had no contact with the R&E Council, rather than the Branch Chief.

The data revealed that NIMH Central Office staff saw the R&E Council as having:

-substantial impact on NIMH Central Office activities in program evaluation; specifically cited were "influencing the topics chosen for

technical assistance activities and 1% evaluation studies", "fostering increased effort for technical assistance on program evaluation", "increasing the effort to rationalize technical assistance activities", "helping to disseminate the results of studies", and "providing valuable feedback to NIMH on the relevance and importance of their work."

- "A slight impact in increasing the awareness of ADAMHA Regional Office staff to program evaluation issues."

- A positive benefit in helping the NIMH officials in their official capacities.

- Only one limited detrimental impact in that one NIMH official felt he sometimes had to argue against "narrowly conceived proposals."

- Suggestions for methods for the R&E Council to increase its effectiveness included "more systematic data collection on reactions to technical assistance."

The responses from the two ADAMHA Regional Offices produced a series of "don't know" in relation to the impact of the R&E Council on NIMH Central Office activities, and in relation to the impact on ADAMHA Regional Offices, the responses were either "don't know" or "no impact."

The data, in conclusion, does indicate substantial impact and effect on the NIMH Central Office towards the goals that were projected for the project (influencing the process of technical assistance and development of NIMH evaluation projects), but having questionable impact on the ADAMHA Regional Offices. This result, to interject a hypothesis at this point, may be a result of the less time spent with ADAMHA Regional Office staff than with NIMH Central Office staff and the difference in the nature of the contacts between the two groups. With the NIMH Central Office staff the contact was intense, via group meetings, and had an element of negotiation associated with it; in contrast, contact with ADAMHA Regional Office staff

was peripheral and only through contact with the R&E Council Chairman.

The Author's Review of Goal Attainment

The author, from a period of two months after the end of the program until the present, conducted a review of task goal achievement. Achievement was measured in relationship to the pre-set intermediate goals, described in an earlier chapter, and was based upon documentation in the log, correspondence and/or the author's knowledge. In the materials below, the author reviews goal attainment.

1. Organizational Development for the Research and Evaluation Council

Goal: (a) Develop a direct linkage between the Council and CMHC program evaluators in order to establish a constituency and institute a feedback communication loop through (1) publishing and disseminating a Research & Evaluation Council Newsletter and (2) establishing Task Forces which would incorporate a broader group of CMHC evaluators in R&E program development.

Degree of Achievement: Goals formulated in this area have been achieved beyond the original expectancy.

-An R&E Council Newsletter was published in June and mailed to 600 CMHC's. Based upon this mailing, the author received "feedback responses" from over 200 evaluators, 98% of whom found the Newsletter informative and useful. As a result of this feedback, it has been agreed to continue the Newsletter on a regular three-times-a-year basis. A second Newsletter was mailed in October 1978, and the author, with the assistance of NCCMHC staff, is in the process of exploring the availability of funds to expand the Newsletter and increase it's circulation.

-Two task forces have been established. The Task Force on 1% Evaluation Funding has been actively functioning for the last three months. It has already produced products that have been usable to the Council and to NIMH.

A Task Force on Manpower & Training is just beginning it's activities.

-In addition to the forementioned achievements, the project has produced an unexpected success. During the project, in conceptualizing methods to establish closer liaison with CMHC staffs, the author recommended to the NCCMHC Annual Program Committee that time be set aside for the R&E Council to have an open information session at the February 1979 Program Meeting. The Program Committee accepted the idea and time has been allotted for all five Councils to have open sessions to report on their activities to CMHC attendees at the Annual Meeting.

Goal: (b) To develop a closer working relationship between the R&E Council and the National Council Board, staff, committees and Councils.

Degree of Attainment: The largest degree of success has been in the area of developing relationships with NCCMHC staff. This attainment began to be seen by activities in the latter part of the project (May and June) and in the months following the end of the project. Among the concrete evidence of this developing relationship are increasing requests by the staff to the author to review and comment on NIMH documents and materials, to testify as a representative of the National Council before DHEW hearings, being recommended by the Executive Director to serve as liaison to a number of different groups (ex., WICHE), and being asked to provide materials and advice on legislative issues.

-Relationships with key Board members and committees have been developed as a result of the Chairman providing Board members with more information on the R&E Council activities and on his developing closer working relationships with individual Board members. Through these activities, the author has come to realize that, in fact, operationally there is only a limited connection to the Board in relation to R&E Council activities. Given the nature of the Council actions and Board interest,

activities and time restraints, it seems appropriate that the R&E Council function quite independently of the Board. The interaction with the Board, it has been recognized, is only key for approval of major policy decisions. Other than this type of limited interaction, it is suggested, would be dysfunctional for the R&E Council and possibly the Board to have extensive interactions.

-In relation to closer working relationships with other NCCMHC Councils, there has been only limited progress. Although, as a result of suggestions by the author and other Council Chairpersons, Council Chairpeople now get together on a regular basis at Board meetings. Contact, other than that, is very circumscribed. It is suggested that part of this lack of contact is determined by time restraints and the nature of the work done by each Council. It is, also, hypothesized that the Council and the Chairpersons organizationally wish to maintain their independence and freedom of operation. Although this may result in deficit in the non-fostering of cooperative activities, it likely enhances some of the organizational stability of the Council.

Goal: (c) To develop a series of policy and positions on important issues of program evaluation to present to the Board for their action.

Degree of Attainment: In relation to this goal, the investigator discovered that, to a large degree, it was inappropriate. Comparatively few issues in effect represent major policy issues in the area of program evaluation. Moreover, the key to implementation activities is not the actions of the Board but rather the actions of the NCCMHC staff and the R&E Council. It has been recognized that even on those issues where the Board reviews, discusses and votes on a position, the effective implementation work is done by the National Council and/or the R&E Council.

Goal: (d) To establish liaison with key professional associations,

(e.g., American Psychological Association, National Association of Social Workers).

Degree of Attainment: Liaisons with professional associations have been established to a degree.

-With the American Psychological Association a liaison was established with Division 27-Community Psychology, which is the key division in relation to CMHC program evaluation. This liaison has resulted in a jointly sponsored research project on program evaluation activities and training needs in CMHC's. Once the study is completed, the data result should be quite valuable to the Council in it's future activities.

-To a limited degree, a liaison was established with the National Association of Social Workers and the Chairman was invited to attend a NASW conference on the Future of Social Work Research.

-With professional groups (e.g., the Evaluation Research Society), no formal liaison has been established until the present time.

2. Development of Organizational Relationships with the Central Office of NIMH

Goal: (a) To develop a formal liaison system with key branches of NIMH with which the Research & Evaluation Council did not have any previous contact. These branches included the Survey and Report Branch of the Division of Biometry and Epidemiology, the Community Mental Health Services Support Branch, the Quality Assurance Program of the Mental Health Care and Service Branch and the Technical Assistance Committee of the Mental Health Services Development Branch, all of which are under the Division of Mental Health Services Programs and the Division of Manpower & Training.

Degree of Attainment: Most of the liaisons projected have been achieved. The results are specifically as follows:

-The Council has established a formal liaison with the Division of

Biometry and Epidemiology. Not only do representatives of the Division attend our meetings but we have also developed an ongoing continuing liaison. This formal liaison has led to cooperative working relationships which have focused on biometry and data collection issues. One member of the Research & Evaluation Council has served as a liaison and attended conferences on Mental Health Statistics, reviewed various Biometry proposals and even worked with the NIMH staff to design an RFP (Request for Proposal) to maximize the ability of Centers to respond.

-The Council has not developed any formal liaison with the Community Support Branch. Based upon a review of this possibility, the Council felt no benefit would accrue from such a liaison.

-A significant but different type of a relationship has been established with the Quality Assurance Program of the Mental Health Care and Service Branch. This relationship grew not out of the formal meeting of the NIMH Branch staff with the R&E Council but out of the joint participation of the Chief of this NIMH Program and the R&E Council Chairman at the APA-SUNY Buffalo sponsored meeting on a CMHC program evaluation survey. Based upon mutual interest in the area of quality assurance, an extensive relationship developed between the NIMH representative and the R&E Council Chairperson. This cooperation eventually, after APA-SUNY Buffalo showed a lack of interest in quality assurance, led to a contract between the NIMH Branch and NCCMHC (operationally the R&E Council) to study quality assurance activities in CMHC's. Contact now encompasses discussions on a wide range of quality assurance issues. Moreover, the relationship has been cemented by the Council being able to provide the Chief of NIMH's Quality Assurance Program with vehicles (e.g., presentations at the NCCMHC Annual Program Meeting) to raise the subject of quality assurance.

-To date, no formal relationship has been developed between the R&E

Council and the Technical Assistance Committee. To press the issues in technical assistance, it has been necessary to have the Executive Director of the National Council deal with higher level NIMH officials (e.g., the Director, Division of Service Programs). Through this type of intervention, we have been able to have important issues (e.g., the amount of technical assistance funds for program evaluation, the problems in the ADAMHA Regional Offices in administering TA funds, the process and priorities for TA funding) discussed.

-To date, there has been no formal liaison between the R&E Council and the NIMH Division of Manpower & Training. Less formal contact has been made and that Division has provided the R&E Council with information it has requested. More formal contacts await the actions of the R&E Council Task Force on Manpower & Training.

Goal: (b) To develop a system whereby the R&E Council could have formal input into the development of 1% evaluation projects and 2% Technical Assistance Programs sponsored by the NIMH Central Office.

Degree of Attainment: The Council has been exceptionally successful in obtaining this desired input.

-Through regular meetings with the Council and the Chief of the NIMH Office of Program Analysis and Evaluation, there exists a formal mechanism whereby the Council reviews proposed 1% evaluation projects and suggests other projects.

-Through regular meetings with the Program Evaluation Specialist of NIMH Mental Health Services Division, processes have been developed where the Council has formal input into developing 2% technical assistance projects.

-This input process has been strengthened by the fact the Council now is invited to attend and participate in the meetings of the Regional Office/Central Office Task Force on Program Evaluation. This Task Force

reviews on 1% evaluation and 2% TA proposals.

Goal: (c) To develop formal methods of communication with NIMH higher echelon officials that would replace the informal methods of communication.

Degree of Attainment: In the course of acting on this objective, it became evident that it would be a mistake to pursue direct communications between the R&E Council and the highest level NIMH officials. It was recognized that the R&E Council itself did not have sufficient power and influence to obtain meaningful responses by the highest level officials. An alternate strategy was developed and successfully implemented. This strategy was to utilize the Executive Director of NCCMHC to request formal responses on key issues from the higher level officials. Given his position and the higher level of power as representing the total National Council, he has been able to obtain responses.

Goal: (d) To develop a formal liaison with the NIMH Central Office/Regional Office Task Force on Program Evaluation in order to participate in planning program evaluation projects and in coordinating Central Office/Regional Office activities on evaluation.

Degree of Attainment: With this objective, high achievement of the goal has been recognized to be of limited value. The R&E Council, as of June, is now regularly invited to attend these meetings. Based upon the attendance at the June meeting and further investigation, the Chairman discovered that the power and influence of the Task Force is quite limited. This limitation is due to the fact the Task Force meets very irregularly, is inefficient in operation and frequently ignores the pressing issues, is not well attended by ADAMHA Regional Office staff and that there is a wide gap between the ADAMHA Regional Offices and NIMH Central Office staff.

Goal: (e) To develop a system whereby members of the R&E Council

would serve on advisory panels to contractors who were given funds by NIMH to conduct program evaluation studies or activities.

Degree of Attainment: In this area, the Council has achieved major advances. In the early spring, NIMH named two R&E Council members to serve on an advisory panel to an NIMH contractor and agreed that, where feasible in the future, R&E Council members would be named to advisory panels on projects that would be developing. NIMH has followed through with their commitment, and appointments have been made in relation to two other projects.

Goal: (f) To encourage NIMH to adopt new procedures that would enable CMHC's to serve as providers for technical assistance training and consultation activities.

Degree of Attainment: As relates to this objective, the Council has achieved substantial success. The new guidelines issued by the NIMH TA Committee indicate that priority in providing TA services should go to CMHC's. Operationally, it has been reported to the Council that ADAMHA Regional Offices has been giving CMHC's more contracts to provide TA.

3. Development of Organization Relationship and Activities with the Ten ADAMHA Regional Offices

Goal: (a) To acquaint the ten ADAMHA Regional Offices with the existence of the Research & Evaluation Council.

Degree of Attainment: The Chairman, in the course of this project, was very successful in acquainting the ten ADAMHA Regional Offices with the existence of the R&E Council. This was accomplished by several vehicles. The initial step was meeting with the Branch Chiefs in the course of the two-day NCCMHC-NIMH-ADAMHA Regional Office meeting in February in Kansas City. The R&E Council survey of Regional Office activities on program evaluation and quality assurance and the subsequent report also acquainted them with the Council.

Goal: (b) To emphasize to these ten ADAMHA Regional Offices the importance of program evaluation and the monitoring and technical assistance projects associated with evaluation.

Degree of Attainment: The Council was partially successful in stressing the importance of evaluation through the direct contact, the evaluation survey and report cited above. It is too early to know if this emphasis has been successful in effecting Regional Office actions. It is suggested that substantially more power than available to the R&E Council may be necessary in changing Regional Office interests in evaluation.

Goal: (c) To suggest and foster the idea that these ten ADAMHA Regional Offices help establish and fund Regional Evaluation Networks which would assist the Regional Offices in planning technical assistance projects in the area of program evaluation.

Degree of Attainment: The R&E Council has strongly achieved stressing the development of Evaluation Networks. It has accomplished this by including it as a recommendation in the study of the ADAMHA Regional Office Program Evaluation activities, by voicing the idea in direct contacts and by offering the suggestion to NIMH Central Office staff. It is too early to know if this suggestion will bear fruit in the Regions without Evaluation Networks. It, however, has been reported by the R&E Council members that ADAMHA Regional Offices demonstrated greater sensitivity to involving CMHC's in the development of TA activities.

Goal: (d) To suggest and foster the idea that these ten ADAMHA Regional Offices develop procedures that make it possible for CMHC's to qualify for funds to provide technical assistance training and consultation.

Degree of Attainment: As was cited earlier in the discussion of the NIMH Central Office TA Committee, there appears to be substantial progress on this area. This progress is noted by the recently issued TA Guidelines

and key reports of the R&E Council members.

Goal: (e) To suggest and foster the idea that these ten ADAMHA Regional Offices develop a mechanism whereby CMHC's receive feedback on their Annual Evaluation Reports and plans which are submitted to meet the requirements under the Program Evaluation Guidelines.

Degree of Attainment: The R&E Council has suggested and fostered this proposal. The Regional Office survey pinpoints the problems in this area and makes important suggestions. It is hypothesized that the results on this issue will be very limited until substantial pressure is exerted on ADAMHA Regional Offices by forces more powerful than the R&E Council.

Scaling Goal Attainment

Utilizing the information presented in the earlier sections of this chapter, the author has attempted to quantify and consolidate the data to provide a clearer picture of the goal attainment associated with the project.

1. Goal Attainment of Task Objectives: To measure achievement of task objectives on a quantifiable basis, the following procedures were utilized to formulate unweighted and weighted numerical scores. The purpose of this quantification was to judge achievement against an "ideal" and to be able to compare achievement by category of task objectives. Two types of scales were employed. The unweighted scale, in which each task is treated as being equal, and a weighted scale, in which each task is given a numerical value consistent with its importance to the overall project.

The unweighted scale was developed by utilizing the following approach:

- (1) Creating a table listing each of the projected tasks and objectives.
- (2) Developing the following categories of achievement and assigning to each a numerical value. The categories developed were: High Achievement = +3; Moderate Achievement = +2; Limited Achievement = +1; or No Achievement = 0. An additional category, Goal Eliminated, was developed and was to be

utilized in cases where based on a variety of factors, the goal was eliminated from the project. For the Goal(s) Eliminated, they were to be removed from consideration in tabulating the quantifiable data. (3) The author reviewed achievement for each of the goals and noted the degree of achievement. (4) The numerical values were totaled for each of the three major task categories, and then a total for the project was computed.

The weighted scale was developed and calculated using the following procedure: (1) A total weight of 100 was given for all the goals associated with the project. For each of the three major categories, a weight was assigned and then a weight formulated for each task within the category. No weight was given for goals or tasks that were eliminated. In developing the weights, the author used the concept of "importance to the project as a whole." It was obvious to the author that some tasks or goals were much more significant than others. These would be assigned a higher weight or numerical value. Although, ideally, this weighting should be done prior to the inception of the project, it was done, in this case, after the completion of the project and as part of the evaluation review activities. It is acknowledged that this increases the potential bias in the process and may reduce the value of these calculations to the evaluation process. The author was aware of this potential bias and attempted to "weigh" goals to avoid this bias. There is, however, no guarantee that the numerical results reported are without prejudice. (2) Utilizing the "raw" scores from the unweighted scale times the weight of each task, it was possible to compute "weighted" scores for each task, the three major categories of tasks and the project as a total.

The results of these computations are presented in Tables 3, 4, 5 and 6.

TABLE 3.--Achievement-Unweighted Scale

Goal/Objective	<u>Degree of Attainment</u>					Eliminate X	Score
	High Achieve- ment +3	Moderate Achieve- ment +2	Limited Achieve- ment +1	No Achieve- ment 0	Goal Changed		
<u>I Organizational</u>							
<u>Development</u>							
1. Develop direct linkage to CMHC evaluators by							
a. publishing newsletter;	X						+ 3
b. establishing Task Forces		X					+ 2
2. To develop closer working relationships between R&E Council &							
a. NCCMHC staff	X						+ 3
b. NCCMHC Board		X					+ 2
3. Develop series of policy and position papers for Board							
						X	
4. Establish liaison with key professional associations							
			X				+ 1
(A total of +11 out of a possible +15) (73%)							+11
<u>II Developing Organ-ization Relation-ships with NIMH Central Office</u>							
1. Develop formal liaison key branches with no formal contact							

TABLE 3-Continued.

Goal/Objective	Degree of Attainment					Goal Eliminate X	Score
	High Achieve- ment +3	Moderate Achieve- ment +2	Limited Achieve- ment +1	No Achieve- ment 0			
Div. Biometry & Epidemiology CMH Services Support Branch	X					X	+ 3
Quality Assurance Program	X						+ 3
TA Committee					X		0
2. Develop formal input into 1% Evaluation and 2% TA projects	X						+ 3
3. Develop formal methods of communi- cation to higher level staff						X	
4. Develop formal liaison with RO/CO Task Force on Program Evaluation	X						+ 3
5. Develop system of R&E Council members serving on advisory boards	X						+ 3
6. Encourage NIMH to develop procedures to enable CMHC's to serve as TA providers	X						+ 3
	(+18 out of a possible +21) (86%)						+18

III Developing Relation-
ships with Ten ADAMHA
Regional Offices

TABLE 3-Continued.

	High Achieve- ment +3	Moderate Achieve- ment +2	Limited Achieve- ment +1	No Achieve- ment 0	Goal Changed Eliminate X	Score
1. Acquaint ADAMHA Offices of R&E Council		X				+ 2
2. Stress the im- portance of program evaluation		X				+ 2
3. Suggest idea of Evaluation Networks			X			+ 1
4. Suggest CMHC's to qualify to provide TA services	X					+ 3
5. Suggest develop- ment of feedback mechanisms on pro- gram evaluation reports and plans			X			+ 1
	(A total of +9 out of +15) (60%)					+ 9
	(A total for the project of +38 out of +51) (74%)					

In the "Unweighted Scale" the goal achievement of tasks associated with the project, a 75% rate of success was achieved. This percentage of the total project, it is suggested, indicates substantial success. By major category, the degree of success varied.

TABLE 4.--Unweighted Scale
Degree of Achievement Summary

Category	Raw Score		% of Successful Achievement
	Achieved	Ideal Score	
1. Organizational Development	+11	+15	73%
2. Developing Organi- zational Relation- ships with the NIMH Central Office	+18	+21	86%
3. Developing Relation- ships with ADAMHA Regional Offices	+ 9	+15	60%

The results indicate that the project was most successful in developing organizational relations with the Central Office of NIMH; slightly less successful in the organizational development tasks; and the least successful in tasks associated with developing relationships with ADAMHA Regional Offices.

TABLE 5.--Project Goal Attainment
Weighted Scale

	Goal	Raw Score Goal Attainment	Weighting Factor	Weighted Score-Goal Attainment
TOTALS		+38	100	+231
I	Organizational Development	+11	40	+ 95
	1. Develop linkages to CMHC evaluators			
	a. publish newsletter	+ 3	10	+ 30
	b. establish Task Forces	+ 2	8	+ 16
	2. Develop closer working relationships to:			
	a. NCCMHC staff	+ 3	9	+ 27
	b. NCCMHC Board	+ 2	9	+ 18
	3. Develop series of policy and position papers for Board	X	-	-
	4. Establish liaison with professional associations	+ 1	4	+ 4
II	Developing Organizational Relationship with NIMH Central Office	+18	40	+102
	1. Develop formal liaison with:			
	Div. of Biometry & Epidemiology	+ 3	5	+ 15
	CMHC Service Support Branch	X	-	-
	Quality Assurance Program	+ 3	6	+ 18
	TA Committee	0	6	0
	2. Formal input into 1% Evaluation and 2% TA projects	+ 3	8	+ 24

TABLE 5-Continued.

Goal	Raw Score Goal Attainment	Weighting Factor	Weighted Score-Goal Attainment
3. Formal communication higher level NIMH officials	X	-	-
4. Develop formal liaison RO/CO Task Force on Program Evaluation	+ 3	8	+ 24
5. R&E Council members serving on advisory boards to NIMH contractors	+ 3	3	+ 9
6. Encourage NIMH to develop procedures to enable CMHC's to serve as TA providers	+ 3	4	+ 12
III Developing Relationships with Ten ADAMHA Regional Offices	+ 9	20	+ 34
1. Acquaint ADAMHA Regional Offices as to existence of R&E Council	+ 2	5	+ 10
2. Stress the importance of Program Evaluation	+ 2	3	+ 6
3. Suggest idea for Evaluation Networks	+ 1	4	+ 4
4. Suggest CMHC's to qualify to provide TA services	+ 3	3	+ 9
5. Suggest development of feedback mechanisms on Program Evaluation Reports and Plans	+ 1	5	+ 5

The "Weighted Scale" shows a total weighted score of +231. Measured against the ideal score of 300, the data indicates a 77% rate of achieved success for the project. The weighted score, which is slightly higher than the unweighted score, clearly indicates that the project was quite successful in terms of overall goal achievement. By major category, there were different levels of success.

TABLE 6.--Weighted Scale
Degree of Achievement Summary

Category	Weighted Score		% of Successful Achievement
	Achieved	Ideal Score	
1. Organizational Development	+ 95	+120	79%
2. Developing Organizational Relationships with NIMH Central Office	+102	+120	85%
3. Developing Relationships with ADAMHA Regional Offices	+ 34	+ 60	57%

The degree of success is similar to the data revealed by the unweighted scale. The most success was in developing organizational relationships with NIMH Central Office; slightly less success in general organizational development tasks; and the least success in developing relationships with ADAMHA Regional Offices.

Goal Attainment of Process Objectives

The project had important process objectives in relation to the methods by which the Research & Evaluation Council functioned. Attempting to quantify the achievement of these objectives was felt to be important to this evaluation. Quantification of achievement of these process objectives is somewhat more difficult than the quantification of task objectives. To complete this quantification, the author utilized a process

similar to that employed for the unweighted scaling. A table which consisted of the process goals plus a scale of attainment (high attainment=+3, moderate attainment=+2, limited attainment=+1, and no attainment=0) was utilized. To classify attainment on the scale, the author utilized data from the survey of R&E Council members and by information accumulated by his own perspective and contacts with Council members. It is acknowledged that this technique suffers from major deficits including the substantial possibility of bias. The author, in quantifying and scaling achievement, was cognizant of the issue of bias and attempted to honestly rate achievement. It is unknown, therefore, the extent of bias incorporated in the results which are reported in Table 7.

TABLE 7.--Process Goal Attainment

Goal	Degree of Attainment				Score
	High Achieve- ment +3	Moderate Achieve- ment +2	Limited Achieve- ment +1	No Achieve- ment 0	
					Total +18
1) to classify and define the role of the Research & Evaluation Council so that influencing the implementation process is given high priority	X				+ 3
2) to reinforce members identification with the Council and it's activities		X			+ 2
3) encourage the active participation of Council members in assuming the responsibility for more task assignments		X			+ 2
4) where possible, provide rewards for members	X				+ 3
5) increase communication between members and the Chairman between semi-annual meetings	X				+ 3
6) develop a system where the Chairman provides members with updated progress reports	X				+ 3
7) establish a mechanism whereby the Council could collectively agree to policy and task assignments at times other than the Council meetings		X			+ 2

It should be noted that for the total project, it is suggested that for process activities, a score of +18 out of an ideal +21 was achieved. This translates into a rate of 86% for success achievement. This rate represents a substantial achievement. There are areas where successful achievement was less than optimum, and these include reinforcing members identification with the Council and its activities, members taking active participation in assuming more task assignments and collective decision making at times other than Council meetings.

CHAPTER VII

CONCLUSIONS

In concluding this paper, four important subjects are discussed: (a) the summary of evaluation results; (b) the importance of the project; (c) new knowledge or ideas emerging from the project; and (d) general implications of the project.

Summary of Evaluation Results

This project had numerous process and task goals. How well did it succeed in achieving these goals? Based upon data in the previous sections, we can provide a response to these questions.

Achievement of Process Goals

The process goals that were established included: recognition that influencing the implementation process needed to be a high priority for the R&E Council; reinforcement of members' identification with the Council; increasing communication between the Chairperson and members; initiating a system of progress reports and establishing mechanisms whereby the Council could collectively agree to policy directions and task assignments at times other than formal meetings. Achievement of those objectives as measured by a rating scale and a member survey were quite substantial. The rating scale indicated an 86% rate of goal achievement (a score of +18 out of an ideal +21). The Council member survey also demonstrated the high rate of success. The most significant success was in the recognition that the R&E Council needs to concern itself with impacting on the implemen-

tation process. High success was also achieved in improving communication and decision making and in providing rewards to members for their participation. Moderate successes were achieved in increasing members identification with the Council and having them assume more task assignments.

Achievement of Task Goals

The task goals of the project were in three areas--the organizational development of the Research & Evaluation Council, the development of organizational relationships with the Central Office of NIMH, and the organizational relationships and activities with the ten ADAMHA Regional Offices. Within each of these areas, there were a number of specific goals. In the area of organizational development of the R&E Council, the specific goals included: developing a direct linkage between the Council and CMHC program evaluators in order to establish a constituency and a feedback/communication loop; developing a closer working relationship between the R&E Council and the NCCMHC Board, staff and Councils; to develop policy and position papers on important issues in program evaluation for the NCCMHC Board; and to establish liaison with key professional organizations. The specific goals as relates to the development of organizational relationships with the Central Office of NIMH included: developing formal liaison with key branches of NIMH; to develop a system whereby the R&E Council had formal input into the development of 1% Evaluation projects and the 2% Technical Assistance programs; develop formal methods of communication with higher levels of NIMH officials; establishment of formal liaison with the NIMH Central Office/Regional Office Task Force on Program Evaluation; to establish a system whereby R&E Council members serve on advisory panels to contractors receiving NIMH funds for evaluation studies, and to encourage NIMH to adopt new procedures that would enable CMHC's to serve as providers for Technical Assistance projects. Finally, as relates to the development

of organizational relationships and activities with ten ADAMHA Regional Offices, the specific goals were: to acquaint the Regional Offices with the existence of the R&E Council; to emphasize to these offices the importance of program evaluation and monitoring and technical assistance activities; to suggest to these Regional Offices the idea that they sponsor and fund regional program evaluation networks; to suggest and foster the idea that Regional Offices develop procedures to make it possible for CMHC's to qualify as providers of technical assistance; and to suggest and develop mechanisms whereby the Regional Offices provide feedback to CMHC's on Annual Evaluation Reports and Plans.

The evaluation data was based upon weighted and unweighted scaling procedures and results from two surveys. The result demonstrated a substantial degree of goal attainment, but this varied by area. The project was highly successful in developing organizational relationships with the Central Office of NIMH; moderately to highly successful in the organizational development tasks and moderately successful in developing relationships with ADAMHA Regional Offices. The unweighted scaling technique indicated 86% of goal achievement as relates to goals in establishing relationships with NIMH Central Office, 73% achievement of goals associated with the R&E Council's development tasks and a 60% achievement for goals associated with developing relationships with ADAMHA Regional Offices. The weighted scale indicated achievement results of 85% for goals in establishing relationships with NIMH Central Office, 79% for R&E Council organizational development goals and 57% for goals in developing relationships with ADAMHA Regional Offices. These results from the scale data were corroborated by surveys of NIMH Central Office staff, ADAMHA Regional Offices and NCCMHC staff.

Within each of the three specified target objectives, there were variations of achievement by specific goal. As relates to organizational

development tasks, great success was achieved in developing direct linkages with CMHC evaluators and in establishing close contact with NCCMHC staff, and moderate success was achieved in establishing relationships with the NCCMHC Board and in establishing R&E Council Task Forces. In the area of establishing relationships with NIMH Central Office staff, substantial successes were achieved in developing formal liaison with key NIMH branches, (the Division of Biometry and Epidemiology, the Mental Health Services Support Branch and the Quality Assurance Program), in developing formal input into 1% Evaluation and 2% Technical Assistance projects; in establishing formal liaison with the Regional Office/Central Office Task Force on Program Evaluation, having R&E Council members serve on advisory boards and encouraging NIMH to develop procedures to enable CMHC's to serve as technical assistance providers. In contrast, there was no success in developing a relationship with NIMH's Technical Assistance Committee. In the third target area, which involved developing relationships with the ten ADAMHA Regional Offices, there was also variation in achievement. Substantial success was attained in suggesting procedures to Regional Offices that would enable CMHC's to qualify as technical assistance providers, moderate success achieved in acquainting these offices of the R&E Council's existence and in stressing the importance of program evaluation, and only limited success was achieved in suggesting to these Regional Offices that they fund Evaluation Networks and providing feedback to CMHC's on Evaluation Plans and Reports.

Project Activities

The evaluation data also provided important descriptive information on project activities. This data indicated that the project required a substantial time commitment. A total of 225 hours or 28.1 eight-hour work days were spent on the project. This amounted to an average of 8.6 hours

per week spent on this project during its six month duration.

The data provided a detailed accounting of time spent in various project activities. It indicated that 21% of all time was spent dealing with R&E Council members, 20% was spent in solo activities, 16% was spent in working with NIMH Central Office staff, 14% was spent interacting with other professional groups, 11% was spent in interacting with the NCCMHC Board, 10% was spent interacting with ADAMHA Regional Office staff and 8% was spent in interacting with NCCMHC staff.

Importance of Project

Policy implementation is, as noted in the introduction, a comparatively new field. Despite this newness, it is a subject that has substantial implications for social work. The implications stem from the basic nature and purposes of social work. Social work, from an ideological viewpoint, is concerned with the development of programs designed to alleviate the sufferings of individuals and groups. Its base is dependent on societal support that involves government, legislative or fiscal acts or policies. It is this substantial dependence on governmental actions that accounts for the relevance of the study of policy implementation for social work.

This project, based upon the results described previously, demonstrates that it is feasible to design and carry out a program that impacts on the policy implementation process. It suggests that intervention can be successful. Furthermore, the project suggests that a well designed and implemented program can be developed based on knowledge drawn from the fields of social work and organizational development. It also suggests that a project of this nature implemented as a social experiment that stresses detailed and comprehensive evaluation can provide information for knowledge building. Thus, we must ask, What new information was

provided by the project? And how might this knowledge be utilized by the field?

New Knowledge or Ideas Emerging from the Project

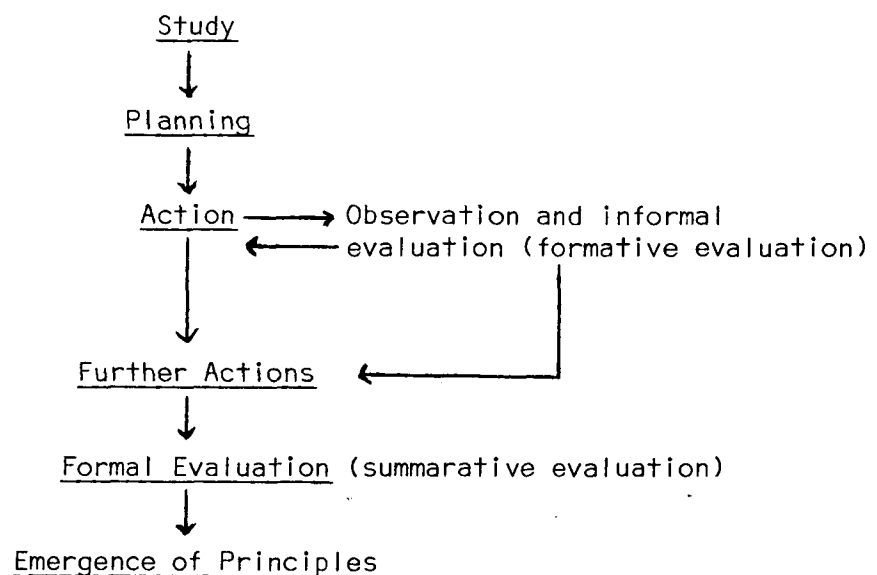
Through the experimental nature of the design of this project and through the analysis by formal evaluation and review of experiential data, substantial new knowledge emerges. This information is presented as key concepts and principles in three distinct areas: (1) general notes on the planning and development of projects designed to impact on policy implementation; (2) strategies for evaluating action programs designed to impact on policy and/or policy implementation; and (3) models for the study of the policy implementation process.

General Notes on Project Planning and Development on Projects Designed to Impact on Policy Implementation

A Model of Program Development

Through the luxury of hindsight, it is possible to delineate the model of program development and implementation utilized in this project.

The model it suggested involves the following processes:



The model employed closely resembles the classic and widely disseminated

approaches utilized both in organizational development and community organization. It does appear to differ in one essential manner. The action phase of this project involved processes of a more complicated nature than is usually illustrated by classical models. Actions sometimes led to immediate further actions. However, most frequently, actions were carefully observed and evaluated (informally) prior to pursuing further actions. This implies that Act A did not lead automatically to Act B, but rather Act A was followed by informal evaluation and led to Act B, or Act C, or Act D, or Act Z. The experience suggests that constant consideration for further actions is essential and that flexibility rather than rigidity is necessary. Furthermore, the experience also pinpoints the fundamental value for evaluation and implies that formative evaluation is a needed built-in component of program development strategies. It should be noted that the formative evaluation suggested does not necessarily require vigorous research design or the skills of an experienced researcher but is readily useable by practitioners or change agents.

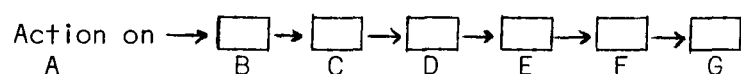
The Concept of the Multi-Dimensioned and Changing Environment

The environment, which consists of the organizations and actors that impinge upon a decision, action(s) or a project is a crucial variable. The environment and its role is a key factor in determining the success or failure of an action or a program. Despite this fact, much in the social work and organizational development literature describes the environment as one dimensional. Environments are, in fact, multi-dimensioned. They are composed of numerous actors (e.g., organizations, interest groups) that may change over time and are almost always involved in constantly changing relationships. These changes do, in essence, create new dimensions and even a new environment. Thus, the planner/implementor must be cognizant of the multiple environmental levels and their ever-changing nature.

Strategies and actions designed to impact on policies and programs, though effective in one stage of the environment, might not be effective in another stage.

The "Multi-Level Intervention" Technique

Another important general concept that emerges from the project evolves around the nature of the action required for a project of this type. Much within the literature of planning suggests a domino approach to action. This can be illustrated as follows:



This type of approach is based upon a simplified concept that envisions actions as occurring along a single dimension and suggests that each single action initiates a sequential series of further actions, (e.g., the toppling of dominoes). However, as noted earlier, environments are quite complicated, and strategies and actions designed to impact on their environment must incorporate recognition of this fact. Thus, the experience of this project suggests that a "multi-level intervention" approach to action is essential. This technique is analogous to firing "buckshot" that scatters in numerous directions. Implied in this approach is the concept of acting on numerous levels and fronts simultaneously. Given the complicated nature of environments, and organizational interactions within these environments, the multiple action approach is necessary. It should be noted that the approach, though analogous to "buckshot", in fact does not imply unplanned, unfocused or scattered activities. Rather, the approach requires comprehensive and sophisticated planning with activities designed to impact on numerous levels. This approach, in contrast to the standard domino concept, offers flexibility and diversity. It also utilizes time more efficiently and avoids the pitfall or traps encountered when a single act fails to

produce the desired effect.

The Leader as a Key Variable

As noted in the theoretical sections of this document, the leader, his role and behaviors, were seen as an important variable. This fact was underscored by the author's experience in the project. Among the elements of leadership that were key were those of "motivator," "executive," "planner," "arbitrator" and "provider of rewards." The importance of the leader providing the group with structure and motivation are essential to the group's performance and to the ultimate success of the project.

Timing and the Opportunity for Action

Projects, to be successful, must exploit every opportunity for action and achievement. Timing of project activities are important. Events frequently occur at a different pace than were originally anticipated. Therefore, rather than rigidly adhering to present plans, the planner/ implementor must demonstrate flexibility in his actions.

Working with Motivated Organizations Within the Environment

Based upon the author's experience with the project, one key principle that emerged was the value of working with motivated components or organizations within the environment. Although in the planning process numerous organizations may be deemed as targets for action, the planner/ implementor may discover that, in operation, the attitudes and behaviors of these organizations may vary. Selected organizations may support the goals of a project while other organizations may oppose the goals. Frequently, by working with organizations that support the project, the planner/ implementor can exploit the opportunity to pursue important avenues. Thus, in fact, particular aspects of the project may be pursued with greater vigor than other aspects. The need to be flexible in changing emphasis is crucial and effects the ultimate outcome.

Resources and Time Available to the Project Leader

One key factor that was not readily known prior to the implementation stage of this project was the time and resources needed by the project leader. Earlier sections pinpointed the substantial time commitment of the worker needed for the project. This substantial time commitment was unexpected. It is suggested that unless the project leader has this time available or an organization or interest group has funds to sponsor a substantial time commitment for a professional, a project of this type cannot be successfully developed. In addition, there was an unexpected need for other resources, e.g., secretarial typing time, xeroxing, availability of funds for long distance telephone calls. The availability of all these resources are crucial for this type of project. These requirements need to be underlined due to the fact that there exists a tendency to underestimate their importance.

Strategies for Evaluating Action Programs Designed to Impact on Policy and/or Policy Implementation

Evaluation is an essential requirement for action programs designed to impact on policy and/or policy implementation. Despite the fundamental importance of evaluation, it has been, especially in social work, neglected in its application to policy action programs. Among the primary reasons hypothesized for this neglect is the continuing professional belief in classical experimental design as the only approach to research. The damage created by this belief is heightened by the fact that practitioners, especially those involved in policy action programs, often lack sophisticated research skills. These two factors intensify the neglect cited previously.

Policy or policy implementation action programs can be evaluated. They, in fact, can be readily evaluated. Furthermore, since they are not readily amenable to classical research design, evaluations that can be

effective need not be complicated.

Based upon his experiences, the author would like to suggest an approach for evaluating these types of programs. The evaluative approach rests on several tenets: (a) "hard" data is not readily available, and use of surrogate measures is essential; (b) to increase the validity of the design, a system needed to be developed that provided information from a number of different sources and perspectives; and (c) it would be impossible for an evaluation to provide summative data. The main thrust of the evaluative system was the development of a systematic methods of data collection. Collection of descriptive data provides the opportunity to quantify and analyze the information from numerous perspectives. This technique, alone, will enable the practitioner to achieve new insights on the project and his strategies and activities. The collection of this descriptive information can easily be supplemented by simple questionnaires, interviews and/or the recording of experiential observations. Moreover, the significance of the information can be heightened by the employment of simple goal attainment scaling techniques. By explicitly delineating goals or criteria of achievement and measuring results against these criteria, the practitioner can observe his success or failure and degrees of each. The substantial benefit of the approach suggested is that it can be readily utilized by practitioners with limited research skills and abilities and by organizations with limited research resources. It should also be restated that the goal of evaluative approaches for policy or policy implementation action programs is to produce formative information or insights that can be used for actions, program development and/or observations on policy development rather than definitive answers.

Models for the Study of the Policy Implementation Process

The project, as it's theoretical base, utilized the models developed

by Rein and Rabinovitz and Van Meter and Van Horn to analyze the policy implementation process. The Rein-Rabinovitz model identified four key phases of implementation: (a) legislation; (b) guidelines; (c) resource distribution; and (d) oversight process. In contrast, Van Meter and Van Horn suggest six components: (a) resources; (b) standards; (c) communications; (d) enforcement; (e) disposition of implementors; and (f) characteristics of the implementing agency. Based upon the experiences of the project, what can we conclude about the relevance of these models? the most significant components? and gaps, if any?

Experiences in the project suggest that most of the components identified in both models are relevant for events in "the real world." It is further suggested that Van Meter-Van Horn model, as a direct result of it's more comprehensive nature, proved the more valuable tool. From a review of both models, it is noted that the key components were, in order of importance: (a) characteristics of the implementing agency; (b) the disposition of the implementors; (c) enforcement-oversight process; (d) communications; and (e) resources. This ranking, it is suggested, may not be applicable to other than the implementation process associated with this project.

Another observation emerging from this project is that there are factors associated with implementation that are not adequately described in either of the two models utilized or in other literature on the subject. One key issue is, How much danger is perceived as confronting the grant program and by whom (key actors, e.g., implementing agency, interest group)? It is suggested that perceptions of threats to programs will drastically effect the actions of important groups or organizations and that those groups that perceive substantial danger will most likely take energetic actions. The experience of the project demonstrated that the

National Council of Community Mental Health Centers (especially through the Council on Research & Evaluation) perceived more danger to the CMHC program than did the governmental organizations--NIMH and the ADAMHA Regional Offices. This perception led to the position of the interest groups pressuring the governing agency for increased enforcement and oversight activities. Recognition of this fact led to the emergence of another key issue, What, in fact, are the roles of interest groups? Much within the professional literature and popular belief conceive of interest groups as narrowly defined organizations stressing the allocation of funding and the removal of regulation and enforcement. From a number of perspectives, they are labeled as being "antidemocratic." Yet, if this project is an illustration, the interest group was intensely "democratic" and advocated the full implementation and enforcement of the legislation. It was, in fact, the government agencies, the representatives of the public, that were "antidemocratic" and strove to impede complete implementation. This observation compels the inclusion in further models of analysis of a more comprehensive role for the examination of roles, activities and motivations of interest groups. The forementioned information requires the citation of another major issue, What is the degree of responsible behavior demonstrated by governmental implementing agencies? The experiences from the project raises this as an important consideration.

Although the development of a model for analyzing the policy implementation process is beyond the scope of this paper, the observations as noted above do suggest further avenues of exploration. Policy implementation is a new and developing field. It is hoped that the points noted in this section will be considered in the literature which will emerge in the future.

General Implications

In summary, there are a number of general implications that evolve

from this project:

- A. It is imperative that substantially more attention be devoted to the study of policy implementation processes. The goals of this increased interest should be to expand the number of cases that have been analyzed and reported in the literature, to continue the process of model development and to develop experimental research projects to impact on implementation processes.
- B. In the model development process, comprehensive and, preferably, multi-disciplined perspectives are essential. It is suggested that the issues which were cited by this investigator be considered as part of this model development.
- C. There is an essential need to increase interest in the evaluation of policy and/or policy implementation action programs and to improve and sharpen our techniques. The importance of this need was cited at numerous points in this paper.

Beyond these general implications, there are specific ramifications for social work that emerge from this project. Social work has, to date, demonstrated only limited interest in the subject of policy implementation. It is essential to increase attention to this subject. Two approaches to increase the importance of this topic to the field are suggested. One task is to introduce the basic concept of implementation into the professional literature and into graduate education. To accomplish this task, it is suggested that articles and monographs that define and describe the implementation process and its relation to social work need to be prepared and disseminated. The curriculum, especially for policy analysis courses at the doctoral level, needs to be expanded to include materials from the policy implementation literature. The introduction of the subject at the doctoral level would expose key groups of individuals to the subject. A

second concomitant task is the development of a literature on the subject that is applicable to social work. Substantially further efforts are needed. It is the hope of the author that these efforts are developed, and the field's interest in policy implementation increases.

APPENDICES

NCCMHC Research & Evaluation Counsel Project

Evaluation by R&E Council Members

Council Member _____

1. How would you define the major goals of the R&E Council at the present time?

A. _____

B. _____

C. _____

D. _____

2. Have the major goals changed over the past six months? Yes No. If yes, how have they changed?

3. To what extent are you in agreement with the R&E Council's present goals?

Strongly agree Agree Not sure Disagree Strongly Disagree

4. If there is disagreement or strong disagreement with goals, how do you disagree with the Research & Evaluation Council goals?

II. Degree of Participation

A. Has your degree of participation in the Council's activities changed in the past six months? Yes No

1. If yes, how? _____

2. Do you consider yourself to be (member) Very active Active Inactive

3. Approximately how much time per month do you spend on Council activities? _____ Hours

III. Communication

A. Has the communication process in relation to the Council, changed in the past six months? Yes No

If yes, how _____

B. Rate the present communication process as relates to the Council.

Very good Good Fair Poor Very Poor

IV. Decision Making

A. Has the decision making process in relation to the Council changed in the past six months? Yes No

If yes, why? _____

B. Do you feel that you are an active participant in the Council decision-making process? ___ Yes ___ No

If no, why? _____

C. Please rate the overall decision-making proces of the R&E Council.

___ Very good ___ Good ___ Fair ___ Poor ___ Very poor

V. Identification & Rewards

A. How strongly do you identify with the R&E Council and its activities?

___ Strong identification ___ Some identification ___ Little identification

B. Describe in what ways you demonstrate your identification with the Council?

1. _____

2. _____

C. Describe the major rewards you receive from your participation on the Council?

1. _____

- 2. _____

- 3. _____

D. Have these rewards changed over the past six months? Yes No

If yes, describe. _____

VI. Overall Council Performance

A. How do you rate the R&E Council's performance over the past six months?

Very ineffective Effective Neither effective nor
ineffective

Ineffective Very Ineffective

B. Cite important Council achievements over the past six months.

- 1. _____

- 2. _____

- 3. _____

4. _____

C. Cite important Council failures over the past six months?

1. _____

2. _____

3. _____

4. _____

EVALUATION OF NCCMHC RESEARCH & EVALUATION COUNCIL ACTIVITIES

Name _____ Title _____

1. As relates to Program Evaluation activities, please indicate what impact, if any, do you perceive that the Research & Evaluation has on the NIMH Central Office?

2. As relates to Program Evaluation activities, please indicate what, if any impact, you perceive that the Research & Evaluation Council has had on NIMH Regional Offices?

3. In what ways has the Research & Evaluation Council and its activities

A. benefited you in your official capacities? _____

B. been detrimental to you in your official capacities? _____

4. In what ways do you think the Council could increase its effectiveness and its impacts? ¹⁵²

ASSESSMENT OF ACTIVITIES OF COUNCIL ON
NCCMHC RESEARCH & EVALUATION DURING JAN., 1978-JUNE, 1978

Respondent _____

1. Please rate the performance of the Research & Evaluation Council as relates to the goals of the National Council in the past six months.

_____ Very effective	_____ Effective	_____ Neither effective nor ineffective
_____ Ineffective	_____ Very ineffective	

2. What do you consider to be the major achievements of the Research & Evaluation Council over the past six months?

- A. _____
- B. _____
- C. _____
- D. _____
- E. _____

3. In what additional ways do you think the Research & Evaluation Council could assist the National Council?

- A. _____
- B. _____
- C. _____
- D. _____
- E. _____

BIBLIOGRAPHY

- Acting Chief, National Institute of Mental Health, Program Analysis & Evaluation Branch. Interview, July 26, 1978.
- Bardach, Eugene. The Implementation Game: What Happens After A Bill Becomes Law. Cambridge, Mass.: The MIT Press, 1977.
- Barnes, Louis. "Organizational Change and Field Experiment Models." Methods of Organizational Research. Edited by Victor Vroom. Pittsburgh: University of Pittsburgh Press, 1971.
- Barth, Edward, and Johnson, Steven. "Community Power and Typology of Social Issues." The Structure of Community Power. Edited by Michael Aiken and Paul Holt. New York: Random House, 1970.
- Bass, Bernard, and Lewitt, Harold. "Experiments in Planning and Operating." Organizational Experiments-Laboratory and Field Research. Edited by William Evan. New York: Harper and Row, 1971.
- Bennis, Warren. The Unconscious Conspiracy. New York: AMACOM, 1976.
- Bennis, Warren. "Changing Organizations." The Planning of Change. Edited by Warren Bennis, Kenneth Benne, and Robert Chin. New York: Holt, Rinehart and Winston, 1969.
- Bennis, Warren. "Leadership A Beleaguered Species?" Organizational Dynamics. Vol. 5 No. (Summer 1976).
- Bennis, Warren; Benne, Kenneth; and Chin, Robert. Editors. The Planning of Change. New York: Holt, Rinehart and Winston, 1969.
- Brager, George. "Goal Formation: An Organizational Perspective." Social Work With Groups-1960. New York: National Association of Social Workers, 1961.
- Buchanan, Garth, and Wholey, Fred. "Federal Level Evaluation." Evaluation. Vol. 1. No. 1. (Fall 1972).
- "Budget of NIMH", Mental Health-Mental Retardation Report. June 20, 1978.
- Campbell, Donald T. "Administrative Experimentation, Institutional Records and Nonreactive Measures." Organizational Experiments-Laboratory and Field Research. Edited by William Evan. New York: Harper and Row, 1971.
- Chin, Robert. "The Utility of System Models and Development Models for Practitioners." The Planning of Change. Edited by Warren Bennis, Kenneth Benne, and Robert Chin. New York: Holt, Rinehart and Winston, 1969.
- Chin, Robert, and Benne, Kenneth. "General Strategies for Effecting Changes in Human Systems." The Planning of Change. Edited by Warren Bennis, Kenneth Benne and Robert Chin. New York: Holt, Rinehart and Winston, 1969.

- Chu, Franklin D., and Trotter, Sharland. The Mental Health Complex. Washington, D.C.: The Center for the Study of Responsive Law, 1972.
- Cook, Thomas J., and Scioli, Frank. "The Interaction of Substance and Methods In The Study of Public Policy." Methodologies for Analyzing Public Policies. Edited by Frank Scioli and Thomas J. Cook. Lexington, Mass.: Lexington Books, 1975.
- Corwin, Ronald. "Patterns of Organizational Conflict." Administrative Science Quarterly. Vol. 19, No. 1. (Winter 1974).
- Davidoff, Isabel; Guttentag, Marcia; and Offut, Joan. Editors. Evaluating Community Mental Health Services: Principles and Practices. Rockville, Md.: NIMH Staff College, 1977. (DHEW#77-465).
- Davis, Howard; Windle, Charles; and Sharfstein, Steven. "Developing Guidelines for Program Evaluation Capability in Community Mental Health Centers." Evaluation. Vol. 4. (1977).
- Derthick, Martha. "Guidelines for Social Service Grants." Policy Sciences. Vol. 7, No. 2. (1976).
- Dermone, Harold J., and Schioberg, Herbert C. "Human Service Trends in the Mid 1970's." Social Casework. Vol. 53, No. 3. (May 1975).
- Director, Public Information and Training, National Council of Community Mental Health Centers. Interview, July 8, 1978.
- Downs, Anthony. Inside Bureaucracy. Boston: Little, Brown & Co., 1967.
- Dye, Thomas R. Understanding Public Policy. Englewood Cliffs, New Jersey: Prentice-Hall, 1964.
- Etzioni, Amitai. Modern Organizations. Englewood Cliffs, New Jersey: Prentice-Hall, 1964.
- Evan, William. Editor. Organizational Experiments-Laboratory and Field Research. New York: Harper and Row, 1971.
- Executive Director, National Council of Community Mental Health Centers. Interviews, October 17, 1977 and May 24, 1978.
- Feder, Judith. "Medicare Implementation and the Policy Process." Journal of Health Politics, Policy and Law. Vol. 2. No. 3. (Fall 1977).
- Felicetti, Daniel. Mental Health and Mental Retardation Politics: The Mind Lobbies in Congress. New York: Praeger Publishers, 1975.
- Foley, Henry. Community Mental Health Legislation. Lexington, Mass.: Lexington Books, 1975.
- Franklin, Jerome L. "Characteristics of Successful and Unsuccessful Organizational Development." Journal of Applied Behavioral Science. Vol. 12. No. 1. (1976).

- French, Wendell L., and Bell, Cecil H. Organizational Development. Englewood Cliffs, New Jersey: Prentice-Hall, 1973.
- Gillespie, David. "Discovering and Describing Goal Conflict." Administration In Social Work. Vol. 1. No. 4. (Winter 1977).
- Gillespie, David, and Mileti, Dennis. "A Refined Model of Differentiation in Organizations." Sociology and Social Research. Vol. 60. No. 3. (March 1975)
- Gouldner, Alvin W. "The Secrets of Organizations." NCSW Social Welfare Forum-1963. New York: Columbia University Press, 1963.
- Hage, Jerald, and Aiken, Michael. Social Change in Complex Organizations. New York: Random House, 1970.
- Hargrove, Erwin C. The Missing Link: The Study of the Implementation of Social Policy. Washington, D.C.: The Urban Institute, 1975.
- Hellriegel, Don, and Slocum, John W. "Organizational Climate: Measures, Research & Contingencies." Academy of Management Journal. Vol. 17. No. 2. (Summer 1974).
- Hersey, Paul, and Blanchard, Kenneth H. Management of Organizational Behavior: Utilizing Human Resources. Englewood Cliffs, New Jersey: Prentice-Hall, 1972.
- Hirsch, Paul. "Organizational Effectiveness-The Institutional Environment." Administrative Science Quarterly. Vol. 20. No. 3. (September 1975).
- Hollander, Edwin P. "Style, Structure and Setting in Organizational Leadership." Administrative Science Quarterly. Vol. 23. No. 1. (March 1971).
- Holloway, Stephen, and Brager, George. "Some Considerations in Planning Organization Change." Administration in Social Work. Vol. 1. No. 4. (Winter 1977).
- Ingram, Helen. "Policy Implementation Through Bargaining: The Input of Federal Grants in Aid." University of Arizona, Department of Government, 1975. (mimeo).
- Jaeger, Jon. "The Citizen in Political Theory." Citizenry and The Hospital. Durham, North Carolina: Department of Health Administration, Duke University, 1974.
- Kalitzny, Arnold, and Veney, James. "Service Implementation in Emergency Human Service Agencies: Individual, Organizational and Community Factors." Journal of Social Service Research. Vol. 1. No. 2. (Winter 1977).
- Katz, Fred E. Autonomy and Organization. New York: Random House, 1968.
- Kaufman, Herbert. "Administrative Decentralization and Political Power." Public Administration Review. Vol. 29. No. 1. (Jan/Feb 1969).

- Knox, William. "Systems for Technological Information Transfer." Science. No. 181, 1973.
- Kurzban, Paul. "Rules and Regulations in Large Scale Organizations: A Theoretical Approach To The Problem." Administration in Social Work. Vol. 1. No. 4, (Winter 1977).
- Levin, Hannah. "Power and Conflict-Key Concepts in Community Dynamics." Citizenry and The Hospital. Durham, North Carolina: Department of Health Administration, 1974.
- Levine, Robert. Public Planning. New York: Basic Books, 1972.
- Levitt, John, and Brown, Lester. "Research and Practice." Social Work. Vol. 23. No. 3, (May 1978)
- Lowenstein, Edward R. "Social Work in Post Industrial Society." Social Work. Vol. 18. No. 6, (November 1973).
- Lowenstein, Edward R., et al. "The Management of Organizational Change: Some Findings and Suggestions." Public Welfare. Vol. 31. No. 1, (Winter 1973).
- Mao Tse Tung. Quotations from Chairman Mao Tse Tung. Peking, China: Foreign Language Press, 1976.
- Marvick, Dwaine. "Elite Politics." American Behavioral Scientist, Vol. 21. No. 1, (September/October 1971).
- Mayer, Robert R. Social Planning and Social Change. Englewood Cliffs, New Jersey: Prentice-Hall, 1972.
- Meyer, Henry, et al. "Social Work and Social Welfare." The Uses of Sociology In The Professions. Edited by Paul F. Lazarfeld, William H. Jewell and Harold L. Wilensky. The Uses of Sociology In the Professions. New York: Basic Books, 1967.
- Miller, S.M., and Rein, Martin. "Change, Ferment and Ideology in the Social Services." Education for Social Work-Proceedings of the Annual Program Meeting-1964. New York: Council on Social Work Education, 1964.
- Mulkay, Michael. "The Mediating Role of The Scientific Elite." Social Studies of Science. Vol. 6. (1976).
- Musto, David F. "The Community Mental Health Movement in Historical Perspective." An Assessment of the Community Mental Health Center Movement. Edited by Walter Barton and Charlotte Sanborn. Lexington, Mass.: D.C. Health and Company, 1977.
- National Council of Community Mental Health Centers. "Annual Report, 1977." Washington, D.C.: NCCMHC, 1978. (mimeo).
- National Council of Community Mental Health Centers. "Board Handbook." Washington, D.C.: NCCMHC, June 1978. (mimeo).

- National Council of Community Mental Health Centers. "Executive Director's Report to the June Meeting of the Board of Directors." Washington, D.C.: NCCMHC, June 1978. (mimeo).
- National Council of Community Mental Health Centers. "Finance and Personnel Committee Report and Minutes." Washington, D.C.: NCCMHC, June 16, 1976. (mimeo).
- National Council of Community Mental Health Centers. "Report of the Personnel and Finance Committee." Washington, D.C.: NCCMHC, May 20, 1978. (mimeo).
- Ozarin, Lucy. "Community Mental Health: Does It Work? A Review of the Evaluation Literature." An Assessment of the Community Mental Health Movement. Edited by Walter Barton and Charlotte Sanborn. Lexington, Mass.: Lexington Books, 1977.
- Perrow, Charles. Organizational Analysis: A Sociological View. Belmont, Cal.: Brooks and Coles, 1970.
- Perrow, Charles. "The Analysis of Goals in Complex Organizations." Human Service Organizations. Edited by Yeshesku Hasenfeld and Richard English. Ann Arbor: University of Michigan Press, 1974.
- Powell, Norman J. Responsible Public Bureaucracy In The United States. Boston: Allyn and Bacon, 1967.
- Pressman, Jeffrey, and Wildavsky, Aaron. Implementation. Berkeley: University of California Press, 1973.
- Program Evaluation Specialist, National Institute of Mental Health. Interview, October 19, 1977.
- Prottas, Jeffrey. "The Power of the Street Level Bureaucrat in Public Service Bureaucracies." Department of Government, Harvard University, 1978. (mimeo).
- Rein, Martin. "Conflicting Goals in Social Policy." The Planning and Delivery of Social Services. Washington, D.C.: National League of Cities, 1969.
- Rein, Martin. "Social Work in Search of a Radical Profession." Social Work. Vol. 15. No. 3, (April 1970).
- Rein, Martin, and Rabinovitz, Francine F. Implementation: A Theoretical Perspective. Cambridge, Mass.: Joint Center for Urban Studies of MIT and Harvard University, 1977.
- Richardson, Elliot. "Conversational Contact." Evaluation. Vol. 1. No. 1, (Fall 1972).
- Rosengren, William. "A Nutcracker Theory of Modern Organizations: A Conflict View." Sociological Focus. Vol. 11, No. 4, (Summer 1978).

- Rossi, Retter H. "Community Decision Making." Administrative Science Quarterly. Vol. 1. No. 4, (March 1957).
- Salanick, Gerald R., and Pfeffer, Jeffrey. "Who Gets Power and How They Hold On To It: A Strategic Contingency Model of Power." Organizational Dynamics. Vol. 5. No. 3, (Winter 1977).
- Salasin, Susan, and Davis, Howard R. "Facilitating the Utilization of Evaluation...The Rocky Road." Evaluating Community Mental Health Services-Principles and Practice. Edited by Isabel Davidoff, Marcia Guttentag and Joan Offut. Rockville, Maryland: NIMH, 1977.
- Sanders, Irwin. "Professional Roles in Planned Change." Centrally Planned Change Prospects and Concepts. New York: NASW, 1964.
- Schwartz, William. "The Social Worker in the Group." New Perspectives on Services to Groups-Theory, Organization and Practice. New York: NASW, 1961.
- Scioli, Frank, and Cook, Thomas. "Experimental Design in Policy Impact Analysis." Methodologies for Analyzing Public Policies. Edited by Frank Scioli and Thomas Cook. Lexington, Mass.: Lexington Books, 1975.
- Seidman, Harold. Politics, Position and Power-The Dynamics of Federal Organization. New York: Oxford University Press, 1970.
- Selltz, Claire, et al. "The Collection of Data By Observation" Organizational Development: Values, Process and Technology. Edited by Newton Margulies and Anthony Raia. New York: McGraw-Hill, 1972.
- Shaw, David. "Size of Share in Task and Motivation in Work Groups." Organizational Experiments-Laboratory and Field Research. Edited by William Evan. New York: Harper and Row, 1971.
- Smalley, Ruth Elizabeth. Theory for Social Work Practice. New York: Columbia University Press, 1967.
- Stedry, Andrew, and Kay, Emanuel. "The Effects of Goal Difficulty on Performance." Organizational Experiments: Laboratory and Field Research. Edited by William Evan. New York: Harper and Row, 1971.
- Stogdill, Ralph M. "Dimensions of Organizational Theory." Approaches to Organizational Design. Edited by James D. Thompson. Pittsburgh: University of Pittsburgh Press, 1971.
- Tannenbaum, Arnold. Social Psychology of the Work Organization. Belmont, Cal.: Brooks/Cole Publishers, 1966.
- Tannenbaum, Robert, and David, Sheldon. "Values, Man and Organizations." Organizational Development: Values, Process and Technology. Edited by Newton Margulies and Anthony Raia. New York: McGraw-Hill, 1972.

- Thompson, James. Organizations in Action: Social Science Basis of Administrative Theory. New York: McGraw-Hill, 1967.
- Thompson, James, and Vroom, Victor H. Editor. Organizational Design and Research. Pittsburgh: University of Pittsburgh Press, 1971.
- U.S. Congress Senate. Health Revenue Sharing and Health Services Act of 1975. Title III-Community Mental Health Centers Amendments. Public Law 94-63, 94th Congress, 1975, S-66.
- U.S. Department of Health, Education and Welfare, National Institute of Mental Health. "Guidelines for Program Evaluation in Community Mental Health Centers." Evaluation. Vol. 4, (1977).
- U.S. Department of Health, Education and Welfare, National Institute of Mental Health. NIMH Organizational Handbook. June 1977. (mimeo).
- U.S. Department of Health, Education and Welfare, Public Health Service. "Functions of Alcohol, Drug Abuse and Mental Health Agency Regional Offices." Federal Register. Vol. 42. No. 232, Dec. 2, 1977.
- U.S. General Accounting Office. Need for More Effective Management of Community Mental Health Centers Program. Report to Congress, B-164031(S). Washington, D.C. August 1974.
- Van Horn, Carl, and Van Meter, Donald. "The Implementation of Intergovernmental Policy." Public Policy Making in a Federal System. Edited by Carl Jones and Robert Thomas. London: Sage Publications, 1976.
- Van Meter, Donald, and Van Horn, Carl. "The Policy Implementation Process: A Conceptual Framework." Administration & Society. Vol. 6. No. 4, (February 1975).
- Vinter, Robert D. "The Essential Components of Social Groups Work Practice." School of Social Work, University of Michigan, 1959. (mimeo).
- Ward, James. "An Approach to Measuring the Effectiveness of Social Services Problems and Resolutions." Administration in Social Work. Vol. 1. No. 4, (Winter 1977).
- Warren, Roland. "Community Change: Some Lessons from the Recent Past." Economic Development Journal. Vol. 9. No. 1, (January 1974).
- Wax, John. "Power Theory and Institutional Change." Social Service Review. Vol. 45. No. 3, (1971).
- Weiss, Carol. "The Politicization of Evaluation Research." The Journal of Social Issues. Vol. 26. No. 4, (1970).
- Weissman, Harold. Community Council and Community Control. Pittsburgh: University of Pittsburgh Press. 1970.
- Williams, Robin. American Society-A Sociological Interpretation. New York: Kropf, 1960.

- Williams, Walter. "Implementation Problems in Federally Funded Programs." Social Program Implementation. Edited by Walter Williams and Richard Elmore. New York: Academic Press, 1976.
- Williams, Walter. "Introduction" Social Program Implementation. Edited by Walter Williams and Richard Elmore. New York: Academic Press, 1976.
- Wilson, James Q. "An Overview of Theories of Planned Change." Centrally Planned Change-Prospects and Concepts. New York: NASW, 1964.
- Yarwood, Dean L., and Nimmo, Dan D. "The Role Approach to Participation & Administrative Behavior." Administrative Science Quarterly. Vol. 21. No. 2, (Spring 1976).
- Young, Kenneth. "Values in the Policy Process." Policy and Politics. Vol. 15 (1977).