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Service Usage as a Measure of Program Effectiveness:

One Agency's Experience

Lisa M. Powers

Submitted in partial fulfillment of
The requirement for the degree of
Master of Social Work

AUGSBURG COLLEGE
MINNEAPOLIS, MINNESOTA
1999

ABSTRACT OF THESIS

SERVICE USAGE AS A MEASURE OF PROGRAM EFFECTIVENESS: ONE AGENCY'S EXPERIENCE

**BY
LISA M. POWERS**

May 20, 1999

This is a program evaluation of a community support program for adults with a serious and persistent mental illness. Since the deinstitutionalization of persons with a serious and persistent mental illness, many programs have been developed with the aim of keeping this population as independent in their communities as possible. Existing research shows the effectiveness of community-based programs in reducing acute care hospitalizations for this population, yet fails to determine which components of these programs are most necessary and for whom. A simple random sample of currently active files (N=38) was conducted, and data was collected on type and frequency of service usage and number of hospitalizations. Subjects were compared on characteristics such as gender, type of services used, and length of involvement in the program. The results indicate that clients who were involved in the program for greater lengths of time and who used more service hours per month had fewer hospitalizations than clients who had less involvement and of a shorter duration in the program.

**MASTER OF SOCIAL WORK
AUGSBURG COLLEGE
MINNEAPOLIS, MINNESOTA**

CERTIFICATE OF APPROVAL

This is to certify that the Master's Thesis of:

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has been approved by the Examining Committee for the thesis requirement for the Master of Social Work Degree.

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I. Introduction: Statement of the Problem

Since the deinstitutionalization of persons with serious and persistent mental illnesses, there has been much discussion of the quality and availability of resources available to this population. The Community Mental Health Centers Act of 1963, aimed at promoting deinstitutionalization through the development of 2000 community mental health centers, did not result in funding for the proposed number of community mental health centers: the funds that *were* allocated did not allow for uniformly high quality programs and services. Since the passage of that act, numerous programs have been developed to address the increased needs and unaddressed concerns of persons with a serious and persistent mental illness.

The purpose of this program evaluation was to evaluate the efficacy of one such program, the Hope Community Support Program, located in St. Cloud, Minnesota. This program's primary goals are to help each client achieve and maintain their highest level of independence and self-sufficiency. This is done through a variety of services that are provided to the clients on an individualized basis. There has been very little research done on the critical components of programs such as the Hope program. An evaluation and comparison of programs such as this would allow for a better understanding of the most critical elements, and to best ascertain which type of client will most benefit. This research project will answer the questions; 1.) Is there an observable relationship between the level of participation in the Hope Community Support Program and the number of hospitalizations? 2.) Is there an observable relationship between type of service involvement and the number of hospitalizations? 3.) Is there an observable relationship between length of involvement in the program and the number of hospitalizations?

Service involvement is conceptualized by the Hope program as receiving services in any combination of the following areas: psychosocial rehabilitation, client outreach, independent

living skills, benefits assistance, housing, employment, crisis assistance, and medication monitoring. Psychosocial rehabilitation is conceptualized as recreational opportunities in the community, socializing, and games and activities at the drop-in center. Client outreach is conceptualized as community education and home visits. Independent living skills is conceptualized as assistance with house cleaning, scheduling time, relationships, cooking, shopping, and budgeting, and group activities at the center. Benefits assistance is defined as assistance in applying for and obtaining Medical Assistance, food stamps, General Assistance, SSI, and other programs. Housing is defined as aid in obtaining affordable housing, moving, home visits, advocating, and on-going support. Employment is defined as support in employment, education and volunteering opportunities. This is done through role-playing, future planning, and referrals. Crisis assistance is conceptualized as supporting, protecting, and helping individuals and family members cope appropriately during crisis situations. Referrals and assistance are provided to diffuse and lessen the situation. Medication monitoring is conceptualized as providing education about medications, support in working with medical professionals, medication reminder systems, and support in taking medications as prescribed. Each of these is operationalized through a simple frequency count.

Study Population

At any given time, there are roughly 200 persons using the Hope Community Support Program's services. A simple random probability sample of current cases was conducted to obtain the study population ($N = 46$). Subjects are adults (18 and over) who are diagnosed as having a serious and persistent mental illness as defined in Rule 79 and who are residents of the two-county area. The study population is primarily whites.

Population Sample

This study was located in a two county area of central Minnesota. These counties are largely rural with numerous cities and towns: no city has a population greater than 60,000. In order to obtain the sample, staff of Hope Community Support Program provided the researcher with a list of all clients currently utilizing services: this list consisted of an identification number only, and did not contain any potentially identifying information. The researcher rolled a die to determine the starting place. In the event a selected case had been open for less than six months, the next case on the list was chosen. Once the sample was obtained, staff of the agency reviewed the case files and gathered data on the following variables: birth date; gender; date clients' cases were opened; admission and discharge dates of hospitalizations; location of hospitalizations; and length of hospitalizations. The dates of caseworker contacts with clients were also provided, as were the number of minutes service was provided in each of the eight service areas. This information is entered into the agency's computerized database and was made available to the researcher.

II. Review of the Literature

History of Deinstitutionalization

The origins of deinstitutionalization in the field of mental health can be traced to the mid-1950s and the advent of psychotropic medications, which allowed numerous people with mental illnesses to be treated in the community rather than spend years in mental institutions. In addition, studies showing the negative effects of institutionalization led to reforms in the community mental health system (Smith, Schwebel, Dunn, & McIver, 1993). According to some authors, the impetus for deinstitutionalization did not arise solely out of concern for the well being of people with chronic mental illnesses. It was an outgrowth of a period in history that emphasized civil rights. "The initial demand to erase social and economic inequities for blacks was translated into a general call to similar action on behalf of other minorities: women, hispanics [sic], native Americans, and the mentally ill" (Durham & La Fond, 1996, p. 618).

The legal system also had its impact on the adoption of deinstitutionalization as a social policy in the U.S. Civil commitment laws in virtually every state were challenged by attorneys who claimed that these laws were depriving people of their Constitutional right to liberty and freedom (Durham & La Fond, 1996). Economics played a role in deinstitutionalization: State institutions suffered from budgetary constraints, an inability to obtain funding, and bureaucratic red tape, making them no longer cost-effective. It was not until the early 1970s, however, that "Americans... committed themselves to a

policy of deinstitutionalization" (Grob, 1994, p. 2). Since that time, the policy of deinstitutionalization has had its supporters and its detractors.

In 1963, President Kennedy signed into law the Community Mental Health Centers Act (CMHC). The Act authorized the funds to build community-based treatment centers for people with mental illness, and at the same time decrease federal dollars for services for this population. "The goal of the program was to provide comprehensive mental health services to all persons regardless of age, sex, national origin, or ability to pay" (Wade, 1993, p. 537). Two thousand model programs were envisioned as providing community mental health centers in every catchment area of the United States. By 1980, fewer than 650 programs existed because federal dollars were insufficient. The community mental health centers that were constructed actually attracted socially maladjusted and less severe clientele than what was originally planned (Durham & La Fond, 1996).

Due to the large number of patients discharged from state institutions, community mental health centers were unable to care for all of them. Inability to secure needed services caused hundreds of thousands of people with mental illness to simply drift "away from any form of mental health care. Mentally ill persons constitute a substantial portion of the homeless population, and many others are not receiving the broad range of services that are necessary to keep them functioning optimally in the community" (Turkheimer & Parry, 1992, p. 649). Whitmer (1983) adds that communities have not been organized to provide help, and that funding has not kept pace with the population.

The state institutions provided for all of the basic needs of the institutionalized patient. Once released, many of them were unable to obtain shelter, clothing, food, or

ways to maintain their hygiene. They were socially stigmatized, which hindered their ability to find work, social activities, transportation, or medical care. "Many deinstitutionalized patients lacked adequate social and self-care skills to meet these needs without assistance" (Smith et al., 1993, p. 976). Cuts in SSI, SSDI, Medicaid, and other federally funded programs during the 1980s hampered the ability of many people with serious mental illnesses to obtain the help they needed (Durham & La Fond, 1996). Torrey (1995) called deinstitutionalization "the largest failed social experiment in twentieth-century America" (p. 1612). He goes on to say that it "...failed not because the vast majority of released individuals cannot live in the community, but because we did not ensure that they receive the medications and aftercare that they need to do so successfully" (p. 1612). Nevertheless, deinstitutionalization continued, regardless of whether or not alternative community treatment was useful or available (Whitmer, 1983). The number of people institutionalized with serious a mental illness shrank from 557,000 in 1955 to 112,000 in 1988 (Smith et al., 1993). Moller and Murphy (1997) report that "approximately 3.3 million adults 18 years of age or older in the civilian, noninstitutionalized United States population have a serious psychiatric disability during any 12-month period," representing "a rate of 18.2 adults per one thousand persons, or 41 million adults" (p. 43).

New Generation of Chronically Mentally Ill

One of the biggest problems not anticipated by proponents of deinstitutionalization was the "new generation" of people with chronic mental illnesses. This population of people, many of them baby boomers, have never been institutionalized

to a state hospital, or have been admitted for only brief stays (Durham & La Fond, 1996; Whitmer, 1983). As the baby boomers reached adulthood in the 1970s, the number of people with serious mental illnesses increased. At this time there was also an increase in the number of people institutionalized, many of them the baby boomers "who were first-time users of the state mental health system" (Durham & La Fond, 1996, p. 626).

Durham and La Fond (1996) also state that these people returned to the state hospitals more frequently and stayed longer. For that reason, "although the number of patients [with chronic mental illnesses] in psychiatric hospitals declined from 557,000 in 1955 to approximately 112,000 in 1988" (Smith et al., 1993, p. 966), and the *average* length of stay to these hospitals has been reduced, the number of admissions and readmissions has actually increased (Kiesler, 1982; Price & Lyder, 1995).

There are some very significant differences in the characteristics of the new generation of people with chronic mental illnesses. The majority of them have not spent years in state mental hospitals, and therefore have not become passive and do not generally do as they are told, unlike the generations of patients before them. For this reason, many of them "frequently do not accept treatment or placement" (Lamb & Shaner, 1993, p. 974), and may not be compliant about taking their medications.

Whitmer (1983) refers to this new generation as "street smart, full of guile, mistrustful, defensive and aggressive, and always ready to fight or flee" (p. 218). And while that may be an over-generalization, the reality is that many of them have been in state hospitals only because they were legally mandated to be there, which goes a long way towards creating mistrust of a system meant to help them.

Community mental health and aftercare programs were geared towards maintaining the independence of the patient who had spent long years in state mental institutions and then released. Mental health workers were ill prepared to work with the person who was neither passive nor compliant (Whitmer, 1983). Not only did this new generation of people with chronic mental illnesses at times resist hospitalization, when longer-term inpatient treatment was needed, help was often unavailable. As institutionalized patients were discharged into the communities, the state hospitals were downsized and the beds disappeared. "Thus many from this new generation who need intermediate or long-term hospitalization are denied it" (Lamb & Shaner, 1993, p. 974).

Lamb and Shaner (1993) believe that the "new generation of chronically mentally ill persons constitute the greatest challenge to the successful implementation of deinstitutionalization. They pose the most difficult clinical problems in community treatment, and they have swelled the ranks of the homeless mentally ill and the mentally ill in jails" (p. 975). Others believe that deinstitutionalization itself created homelessness (Durham & La Fond, 1996). Durham and La Fond (1996) go on to state, however, that only about 10-15% of the homeless population actually suffer from a serious mental disorder, although up to one half of the homeless population have been patients in a psychiatric hospital at one time. Belcher (1988) claims that "the homeless mentally ill population has mental illness that is more severe than that of the broader mentally ill population" (p. 399).

Homelessness and Mental Illness

Compared to other groups of homeless people, such as single mothers and alcoholics, the seriously mentally ill are at a greater risk to become and remain homeless (Durham & La Fond, 1996). This is largely due to gaps in the service delivery system brought about by deinstitutionalization. The life of a homeless person is generally unstructured, and many of the homeless mentally ill lack the cognitive ability to do more than just exist from day to day, at times out of touch with reality. For many of them, voluntary outpatient treatment does not provide the structure they need; they seldom seek psychiatric treatment voluntarily, but rather on an emergency basis through their contacts with police officers and the criminal justice system (Belcher, 1988).

Evidence also exists that reforms in the civil commitment laws have contributed to homelessness and involvement in the criminal justice system (Belcher, 1988; Durham & La Fond, 1996). "In 1978, the President's Commission on Mental Health defined the objective of the *least restrictive environment* as 'maintaining the greatest degree of freedom, self determination, autonomy, dignity, and the integrity of body, mind, and spirit for the individual while he or she participates in treatment or receives services' " (Belcher, 1988, p. 398). For the most part, a person with a serious and persistent mental illness cannot be involuntarily committed unless he or she poses a risk of danger to him or herself or to another (suicidal or homicidal). Therefore, persons who refuse hospitalization may not be mandated to seek mental health services. As far as social service agencies and the criminal justice system are concerned, the focus has been on "the restrictiveness of the intervention without also considering the degree of freedom that

could be restored through treatment," and "quality of life has been ignored" (Belcher, 1988, p. 398).

Criminal Justice System

Whitmer (1983) refers to individuals who end up in the criminal justice system instead of the mental health system as "forfeited patients." These forfeited patients "are being arrested for minor criminal acts that are really manifestations of their illness, their lack of treatment, and the lack of structure in their lives" (Lamb & Shaner, 1993, p. 976). Once involved in the criminal justice system, the courts must determine if these people are legally insane or mentally incompetent. The process is quite lengthy, and the person remains incarcerated while this is being determined. If the forfeited patient is, in fact, found to be mentally incompetent or legally insane, he or she may be committed for 90 days in a state hospital, and will only be released once he or she can demonstrate that she or he is no longer dangerous. The need for psychiatric treatment is often seen as secondary to the protection of civil liberties, and the courts will seldom pursue commitment, not seeing the lengthy process as being in the forfeited patients best interest.

If a person with a serious and persistent mental illness is not deemed to be a danger to self or others, and cannot therefore be mandated to seek treatment, what then becomes of that person? In many cases, this person now becomes part of the criminal justice system, as opposed to the mental health system (Bittman & Convit, 1993). "(T)he Los Angeles County jail system, with 3300 of its 21,000 inmates requiring 'mental health services on a daily basis,' has become de facto 'the largest mental institution in the

country' " (Torrey, 1995, p. 1612). Durham and La Fond (1996) estimate that 5% to 10% of prison inmates have a mental illness, while Torrey (1995) gives an estimate of 6% to 15%. The US Department of Justice in 1994 released information concerning the 2,035,275 people who in 1993 were either on parole, in jail, or in a state or federal prison. Using an average of 8% of these people having a serious mental illness means that 162,822 individuals who are involved in the criminal justice system have some type of serious mental illness: twice the number of individuals in state hospitals on a given day (Torrey, 1995). Turkheimer and Parry (1992) criticize deinstitutionalization for having a "criminalization" effect, citing the large number of people with serious mental illnesses involved in the criminal justice system.

Transinstitutionalization

In addition to the number of people with chronic mental illnesses involved in the criminal justice system, deinstitutionalization has resulted in what Turkheimer and Parry (1992) term "transinstitutionalization." They claim that hundreds of thousands of people with chronic mental illness now live in group homes or board-and-care facilities, with another 750,000 living in nursing homes. This is in addition to the increasingly large number of people seen for brief stays in hospital mental health units. According to Lamb and Shaner (1993), this transinstitutionalization is actually an avoiding of responsibility for the people with chronic mental illnesses. They cite hospitals' raising of admission criteria, along with channeling them into other systems, as evidence of avoiding responsibility (Lamb & Shaner, 1993).

Failure of Deinstitutionalization

Whitmer (1983) further examines the "failure" of deinstitutionalization, focusing on private and general hospitals that admit people with serious and persistent mental illnesses. Because of the large numbers of people seeking hospitalization, admission criteria has been raised in many hospitals. To be admitted, one must be either suicidal or in danger of harming someone else. By the time patients have reached this point they have decompensated to such an extent that hospital personnel can do little more than rely on medications to alleviate symptoms. Due to the limited stays authorized by insurance companies, once the patient is no longer a danger to self or others, he or she is discharged. This leaves the patient with no attachment to a mental health professional needed for further work, no ability to recognize the warning signs of future decompensation, and no insight into the origins of his or her difficulties. Whitmer (1983) reports on the consequences: "80 percent of all patients do not continue medication after discharge, and over 70 percent do not initiate contact with outpatient programs" (p. 218).

Numerous studies exist showing the benefits of deinstitutionalization and non-institutionalization for people with chronic mental illnesses. All of these studies state that the availability of community resources is directly related to positive outcomes. Grob (1994) found "that individuals with severe mental disorders prefer and do better in community settings that provide economic resources, particularly vocational rehabilitation, and status in terms of empowerment that provides a feeling of mastery rather than a sense of dependency" (p. 294). Durham and La Fond (1996) state that aftercare, community treatment, and long-term follow-up are requirements for successful

deinstitutionalization, and that this type of treatment is not only less costly but more effective.

In a review of ten studies on the effects of institutionalization versus non-institutionalization, Kiesler (1982) found no instances where hospitalization was more beneficial than alternative care. He found alternative care strategies, i.e., non-institutionalization, to be more beneficial on areas such as school attendance and employment. One of these studies reported higher employment, greater living independence, better school attendance, a greater likelihood of having long-term friendships, and less psychopathology (Kiesler, 1982). In comparisons of hospitalization characteristics, the never hospitalized ended up in hospitals less often than deinstitutionalized patients were re-hospitalized. Of the clients in alternative care groups that did end up hospitalized, the average length of stay was significantly shorter than those that were re-hospitalized after deinstitutionalization (Kiesler, 1982). All of the previously mentioned studies found that the type of alternative care had little impact on the likelihood of future hospitalization, although all of them focused on social skills building, vocational rehabilitation, and basic support.

Positives of Deinstitutionalization

In a study on the "biopsychosocial legacy of deinstitutionalization," Bachrach (1993) outlines six positive outcomes of deinstitutionalization. One such outcome is the importance of individuality in service systems. She cites differences in symptomology, motivation, and personal preferences, as well as the very differences among people in general as reasons for the need for individualized services. This ties directly in to two

other principles, the need for service users to be active in their treatment planning, and the need to respond to cultural and community differences. In other words, for deinstitutionalization to be effective, community services must be broad-based and flexible enough to work with the diverse populations they intend to serve. In addition, they must be consumer driven, with clients determining what they need and hope to achieve.

This, of course, ties in to another biopsychosocial legacy, or principle, that of continuity of care. This includes not just the immediate availability of resources, but the availability of these resources for extended, and sometimes life-long, periods of time. Deinstitutionalization has taught us that mental illness is not a myth. Mental illnesses, just like somatic illnesses, sometimes require hospitalization. A fifth principle of deinstitutionalization is that hospitalization is sometimes necessary. Bachrach (1993) states, "It has become increasingly apparent that community-based care is not necessarily the most benign alternative for all mentally ill people at all times" (p. 524). The examples of homelessness and involvement in the criminal justice system have shown us that not everyone is able or willing to make use of community resources. For these reasons, hospitalization must always remain an option.

The sixth biopsychosocial principle that Bachrach (1993) describes is the need for outcome measures that are realistic, clinically relevant, and flexible. What an agency describes as a desired outcome of its treatment program may not be applicable or appropriate to every person the agency serves. In other words, the effectiveness and validity of a program's treatment model may not be accurately measured by such variables as employment and remaining in the community without ever needing

hospitalization. For some clients, success can be seen in smaller steps along the way to a desired outcome (Bachrach, 1993).

Program Innovations

It is apparent that there are no clear answers on whether or not deinstitutionalization was a "good" thing. It would appear that the policy of deinstitutionalization itself is neither good nor bad. The negative affects of this movement may instead stem from a lack of foresight. What is clear is that when support exists, both from community members and community resources, a majority of people living with mental illnesses do benefit. It is only when people are unable or unwilling to access appropriate resources that living in the community poses such problems. As communities become more aware of persons living with mental illnesses, a response becomes possible. Innovations such as case management, assertive community treatment, and community-based rehabilitation programs appear to be addressing some of these problems.

Saraceno (1997) defines rehabilitation as "the clever and rational use of human resources and health and social services" (p. 10). Strategies are oriented towards empowering clients through the development of their social skills and by activating the community resources necessary for them to adapt to their chosen environments (Saraceno, 1997; Mallik, Reeves, & Dellario, 1998). Psychosocial rehabilitation is neither an outcome nor a set of techniques, but rather a process for "restoring the full citizenship of the person with a mental illness" (Saraceno, 1997, p. 11). Research has shown that community-based programs utilizing rehabilitation models offer an effective

means of increasing the level of community functioning for persons with a mental illness (Lehman, 1998; Connors, Siddique, Van Vulpen, & Mulhall, 1998).

Theoretical Framework

One of the primary goals of deinstitutionalization was to decrease the number and frequency of acute-care hospitalizations of persons with a serious and persistent mental illness. Unfortunately, the decrease in the population of hospitalized patients occurred more rapidly than did an increase in the availability of community supports. As a result of the deinstitutionalization policy, increasing attention has been paid to community support systems for these people. The types of support systems may vary, though many of them utilize an ecological framework.

This ecological framework stresses the need for social work interventions that include the client's family, social, and cultural environments (Pardeck, 1996). Assessment of and intervention with clients must focus not only on the client and his or her environment, but also on the interactions between them (Libasi, 1988; Pardeck, 1996). "The ecological perspective defines human problems as the outcome of transactions between the environment and the individual. Conceptualizing presenting problems of clients in this way takes social work practice back to the early work of Mary Richmond who was well aware that a disjunction between the person and the environment could have negative consequences on physical, emotional, and social well-being" (Pardeck, 1996, p. 197).

The core feature of the ecological perspective is the belief that people and their environments are both interdependent and interactive. In other words, one helps shape

the other (Libasi, 1988). This view allows the social worker "to understand the impact of environment, both social and physical, on a client's mental health, and more important, to use the environment to support the coping and adaptive efforts of individual clients and groups of clients in dealing with the stress of daily living" (Libasi, 1988, p. 89).

Both Libasi (1988) and Pardeck (1996) offer the ecological perspective as a holistic, humanistic approach to the issue of mental health. Traditional views, such as the illness, disease, or sickness models tend to view the person as the problem, focusing not on the whole person, but on individual pathology. The ecological approach stresses the importance of assessing the "goodness of fit" between the person and the environment, allowing "the practitioner to acknowledge but deemphasize (sic) the disability and to emphasize the strengths, assets, and potentialities" (Libasi, 1988, p. 91).

Practitioners who utilize the ecological approach work with the client *in vivo* to help obtain the necessary resources needed for the client to reach his or her full potential (Libasi, 1988). This means an emphasis on personal growth, goal attainment, and enhancing the fit between "the person's needs and skills and the demands and resources in the environment" (Libasi, 1988, p. 91). In order to create a better fit, practitioners work to change the human service delivery system by working with "the ecosystems that impact on their social functioning" (Pardeck, 1996, p. 197). The social worker focuses not on curing clients, but on helping clients to improve their social functioning and to release their full potential in order that they may best adapt to and cope with their disability (Libasi, 1988).

The Hope Community Support Program's interventions adhere to the recommendations set forth by the ecological perspective through the provision of eight

different services described previously. Staff members focus on the goodness of fit between each client and his or her own environment, tailoring services to meet the needs of each individual. Clients are assisted with goal setting and attainment, which often includes working with the clients in their homes to increase their adaptive abilities in areas such as cooking, house cleaning, and shopping. The drop-in center at the agency provides a common meeting ground for clients and enhances their socialization skills, as well as increasing their social support network. Another way in which the agency works to enhance the fit between clients and their environments lies in advocacy. Staff members provide support in working with medical professionals, obtaining housing, benefits, and employment, and encourage clients to take an active role in changing the service delivery system.

III. Methodology

Research Design

This research is an evaluation of the Hope Community Support Program. This program's goal is to assist its clients, persons diagnosed as having a serious and persistent mental illness, to live as independently as possible in the community. It is the researcher's understanding that psychiatric diagnosis is determined using the American Psychiatric Association's Diagnostic and Statistical Manual (DSM), although it is unclear which version was used. This study used a case file review to provide a deductive, explanatory study of the individuals participating in the Hope program. Participants in this program use services in any or all of the following eight areas: client outreach, crisis assistance, medication monitoring, independent living skills, benefits assistance, psychosocial rehabilitation, employment, and housing. The amount of time each of these services is used is recorded by the participants' caseworker and entered into the agency's database under the client identification number. The dates, lengths of stay, and place of hospitalization are also documented in the client's case file by the caseworker.

A simple random probability sample of current cases, provided to the researcher by the agency director, was used to determine the sample population. Agency caseworkers reviewed the case records of the sample population in order to gather on the number of hospitalizations at regional treatment centers and local hospitals. This data was compared to type and frequency of services utilized by the participants.

Concepts/Units of Analysis

The units of analysis in this study are those individuals currently utilizing the Hope Community Support Program's services. For the purpose of this study, hospitalization was defined as participants' hospitalizations at any regional treatment center or community hospitals, and was operationalized using a simple frequency count.

Data Gathering Procedure

The researcher discussed the proposed research project with the thesis advisor and the research instructor. Once the research project was decided on, the director of Hope Community Support Program was contacted by phone and the possibility of conducting a program evaluation was discussed. A letter was sent to the director outlining the research proposal (see Appendix A) and, in turn the agency director sent a letter of permission to conduct the research. Final approval was sought and obtained from Augsburg College's Institutional Review Board (IRB) (see Appendix B). While awaiting approval from the college, the data collection instrument was developed. This instrument was to be completed by the agency caseworkers and included subject gender, the date the file was opened, psychiatric diagnoses, and the dates and places of subjects' hospitalizations (see Appendix C).

Once IRB approval was received, the agency director was asked to provide a list of all cases currently open, which was to include only the client identification number, birth date, and the date the information was gathered. Once this was completed, the researcher went to the agency to conduct the sample. A die was rolled in the presence of the director to determine the starting place, and every fifth case was selected. In

instances where a selected case had been opened less than six months, the next case on the list was selected instead. The researcher then wrote the identification numbers of the selected cases on the data collection instruments and gave them to the agency director, along with a cover letter explaining the research project to the caseworkers (see Appendix D).

The director then distributed the data collection instruments and cover letters to the appropriate caseworkers, who reviewed the client case files in order to gather the information needed to fill out the data collection instruments. Once completed, these instruments were turned in to the director. The director was also given a list of the selected cases, and was asked to gather information on service usage for each month of the study period. This information is entered into the agency's database each month by the caseworkers, and includes only the client identification numbers and the amount of services used in each of the eight service areas for that month. The researcher was contacted by phone once the agency director and caseworkers gathered all of the data. The data was then collected by the researcher and brought to the researcher's home to be analyzed.

It was intended that data would be gathered for the period from January 1, 1995 through the date the data was collected. On January 1, 1997 however, the agency changed its data gathering methods: prior to that time, several of the services provided had been included under an "Other" category. As of January 1, 1997 the services were re-categorized into the eight categories previously mentioned. There was also a gap in the reporting on service usage data for the period from February 1, 1997 to May 31,

1997. As a result, a 20-month study period from June 1, 1997 to January 31, 1999 was used for the research.

A simple random sample of the 235 cases open at the time of the study was conducted. Sampling yielded a study sample population of 46. Seven of the 46 cases either had no contact with the agency after the initial intake or were contracted out through a county not in the agency's service area, causing them to be excluded from the study sample. In one case, the client's caseworker stated that the client had been hospitalized during the study period but was unable to document the number of hospitalizations, so that case was also excluded. The final sample population yielded 38 cases; 11 males and 27 females. The sample population ranged in age from 20 to 73 years old, with a mean of 41.8 years.

IV. Presentation and Discussion of Findings

Results

Fifty-three percent of the sample (N=20) had multiple diagnoses (according to the American Psychiatric Association's Diagnostic and Statistical Manual), meaning that they fell into several of the categories listed below. This group was comprised of 45% (N=5) of the males and 56% (N=15) of the females. The majority of the subjects (N=19) had a psychiatric diagnosis of a psychotic disorder (e.g., schizophrenia, schizoaffective disorder). The smallest group in the sample (N=6) were all female and had a psychiatric diagnosis of an anxiety disorder (e.g., post-traumatic stress disorder, panic disorder). (See Table 1.1).

| | Male | | Female | | Total* | |
|-----------------------------|------|----|--------|----|--------|----|
| | N | % | N | % | N | % |
| Multiple Diagnoses | 5 | 45 | 15 | 56 | 20 | 53 |
| Psychotic Disorder | 8 | 73 | 11 | 41 | 19 | 50 |
| Mood Disorder | 2 | 18 | 15 | 56 | 17 | 45 |
| Personality Disorder | 3 | 27 | 9 | 33 | 12 | 32 |
| Anxiety Disorder | - | - | 6 | 22 | 6 | 16 |
| Other | 3 | 27 | 7 | 26 | 10 | 26 |

Table 1.1 Psychiatric Diagnoses of Sample Population

*Numbers do not total 100% as subjects could fall in several categories

Sixty-one percent of the subjects (N=23), eight males and 15 females, had no hospitalizations during the study period. Twenty-one percent of the subjects (N=8), three males and five females, were hospitalized one time during the study period. No males in

the sample had more than one hospitalization during the study period. Two females had two hospitalizations each, and five females had three hospitalizations each. The average number of hospitalizations for all subjects was 0.71 during the study period. For males that number was 0.27, while females averaged 0.87 hospitalizations during the study period, an average of 60% more hospitalizations than males in the sample. (See Table 1.2).

| Length of Involvement | Ave. Number of Hospitalizations | | | | | |
|-----------------------|---------------------------------|-------|--------|-------|-------|-------|
| | Male | | Female | | Total | |
| | N | Hosp. | N | Hosp. | N | Hosp. |
| 6-24 Months | 2 | 0 | 10 | 0.80 | 12 | 0.67 |
| 25-48 Months | 4 | 0.75 | 8 | 0.88 | 12 | 0.83 |
| 49-72 Months | 4 | 0 | 3 | 2.00 | 7 | 0.86 |
| 73-96 Months | - | - | 2 | 1.00 | 2 | 1.00 |
| 97-120 Months | 1 | 0 | 3 | 0.33 | 4 | 0.25 |
| 120+ Months | - | - | 1 | 0 | 1 | 0 |
| Total | 11 | 0.27 | 27 | 0.87 | 38 | 0.71 |

Table 1.2 Average Number of Hospitalizations by Length of Involvement

Level of Participation

The average number of hours of services used per month by the subjects was 11.19 hours. Males used an average of 11.96 hours, while females used an average of 10.87 hours per month. Subjects with no hospitalizations during the study period used an average of 9.5 hours of services per month. Males used an average of 10.3 hours and females used an average of 9.0 hours per month. Eight subjects were hospitalized once

during the study period and used an average of 17.8 hours per month. Of these, males (N=3) used an average of 16.4 hours per month and females (N=5) used an average of 18.6 hours of services per month. The two females with two hospitalizations each used an average of 9.6 hours per month. The five females with three hospitalizations each used an average of 9.2 hours of services per month. (See Table 1.3)

| No. of Hospitalizations | Average Amount of Services Used Per Month (In Hours) | | | | | |
|-------------------------|--|-------|--------|-------|-------|-------|
| | Male | | Female | | Total | |
| | N | Hours | N | Hours | N | Hours |
| 0 | 8 | 10.3 | 15 | 9.0 | 23 | 9.5 |
| 1 | 3 | 16.4 | 5 | 18.6 | 8 | 17.8 |
| 2 | - | - | 2 | 9.6 | 2 | 9.6 |
| 3 | - | - | 5 | 9.2 | 5 | 9.2 |
| Total | 11 | 11.96 | 27 | 10.87 | 38 | 11.19 |

Table 1.3 Average Amount of Services Used Per Month in Hours

Clients with one hospitalization used an average of 6.61 more service hours per month than the average, and an average of 8.3 more service hours than subjects with no hospitalizations. Females used an average of 1.09 hours less per month than males. Females with one hospitalization used an average of 9.1 hours more than clients with no hospitalizations, 9.6 more hours than females with no hospitalizations, and 8.3 hours more than males with no hospitalizations.

Subjects with one hospitalization used more hours per month than all other subjects. While it is difficult to determine cause and effect, two possible explanations exist. The first explanation is that an increase in service hours used by the subjects

preceded a hospitalization. If this is the case, agency caseworkers could use this information as a possible warning sign with their clients. Another possible explanation is that subjects used more service hours in the months following a hospitalization, possibly with the hopes of preventing future hospitalizations. Subjects with two and three hospitalizations used fewer service hours per month on average, which could explain the increased number of hospitalizations.

Length of Involvement

The average length of involvement for subjects was 45.5 months, with a range of 6 to 125 months. Males had an average length of involvement in the program of 44.9 months and females 45.7 months. Subjects with no hospitalizations had an average length of involvement of 46.8 months: males averaged 48.9 months and females 45.7 months. Subjects with one hospitalization averaged 48.8 months of involvement, with males averaging 34.3 months and females averaging 57.4 months. The two females with two hospitalizations each averaged 34.5 months of involvement. The five females with three hospitalizations each averaged 38.8 months of involvement in the program. (See Table 1.4)

| No. of Hospitalizations | Average Length of Involvement (In Months) | | | | | |
|-------------------------|---|--------|--------|--------|-------|--------|
| | Male | | Female | | Total | |
| | N | Months | N | Months | N | Months |
| 0 | 8 | 48.9 | 15 | 45.7 | 23 | 46.8 |
| 1 | 3 | 34.3 | 5 | 57.4 | 8 | 48.8 |
| 2 | - | - | 2 | 34.5 | 2 | 34.5 |
| 3 | - | - | 5 | 38.8 | 5 | 38.8 |
| Total | 11 | 44.9 | 27 | 45.7 | 38 | 45.5 |

Table 1.4 Average Length of Involvement in Months

Twelve clients were involved in the program between six and 24 months and used an average of 5.4 hours of services per month. Twelve subjects were involved in the program from 25 to 48 months and used an average of 11.5 hours of services per month. Seven subjects were involved from 49 to 72 months and used an average of 12.6 hours per month. Two clients were involved from 73 to 96 months and averaged using 29.1 hours of services per month. Four subjects were involved from 97 to 120 months and used an average of 16.1 hours per month. One client was involved in the program for 125 months and used an average of 11.4 hours of services per month. (See Table 1.5)

| Length of Involvement | Average Amount of Services Used Per Month | | | | | |
|-----------------------|---|-------|--------|-------|-------|-------|
| | Male | | Female | | Total | |
| | N | Hours | N | Hours | N | Hours |
| 6-24 Months | 2 | 3.8 | 10 | 5.7 | 12 | 5.4 |
| 25-48 Months | 4 | 14.9 | 8 | 9.8 | 12 | 11.5 |
| 49-72 Months | 4 | 13.2 | 3 | 11.8 | 7 | 12.6 |
| 73-96 Months | - | - | 2 | 29.1 | 2 | 29.1 |
| 97-120 Months | 1 | 11.8 | 3 | 17.5 | 4 | 16.1 |
| 120+ Months | - | - | 1 | 11.4 | 1 | 11.4 |
| Total | 11 | 11.96 | 27 | 10.87 | 38 | 11.19 |

Table 1.5 Average Amount of Services Used Per Month in Hours

Of the subjects who had been in the program from six to 24 months, 67% (N=8) had no hospitalizations, 17% (N=2) had one hospitalization, and 17% (N=2) had three hospitalizations. Fourteen clients were involved in the program 49 months or over; nine of these had no hospitalizations. Two females had three hospitalizations each and two females had one hospitalization each. Seven clients were involved in the program over 73 months: three of these subjects had one hospitalization each. Sixty-four percent of the subjects (N=24) were involved in the program for 48 months or less. Fourteen of these subjects had no hospitalizations, five had one hospitalization each, two had two hospitalizations each, and three had three hospitalizations each. (See Table 1.6 and Table 1.7).

| Months of Involvement | Number of Hospitalizations | | | | | | | | | |
|-----------------------|----------------------------|-----------|----------|-----------|----------|----------|----------|-----------|------------|------------|
| | 0 | | 1 | | 2 | | 3 | | Cumulative | |
| | N | % | N | % | N | % | N | % | N | % |
| 6-24 | 8 | 21 | 2 | 5 | - | - | 2 | 5 | 12 | 32 |
| 25-48 | 6 | 16 | 3 | 8 | 2 | 5 | 1 | 3 | 12 | 32 |
| 49-72 | 5 | 13 | - | - | - | - | 2 | 5 | 7 | 18 |
| 73-96 | - | - | 2 | 5 | - | - | - | - | 2 | 5 |
| 97-120 | 3 | 8 | 1 | 3 | - | - | - | - | 4 | 11 |
| 120+ | 1 | 3 | - | - | - | - | - | - | 1 | 3 |
| Total | 23 | 61 | 8 | 21 | 2 | 5 | 5 | 13 | 38 | 100 |

Table 1.6 Average Number of Hospitalizations by Length of Involvement

| Months of Involvement | | Number of Hospitalizations | | | | | | | |
|-----------------------|--------------|----------------------------|------------|----------|------------|----------|-----------|----------|-----------|
| | | 0 | | 1 | | 2 | | 3 | |
| | | N | % | N | % | N | % | N | % |
| 6-24 | Male | 2 | 17 | - | - | - | - | - | - |
| | Female | 6 | 50 | 2 | 17 | - | - | 2 | 17 |
| | Total | 8 | 67 | 2 | 17 | - | - | 2 | 17 |
| 25-48 | Male | 1 | 8 | 3 | 25 | - | - | - | - |
| | Female | 5 | 42 | - | - | 2 | 17 | 1 | 8 |
| | Total | 6 | 50 | 3 | 25 | 2 | 17 | 1 | 8 |
| 49-72 | Male | 4 | 57 | - | - | - | - | - | - |
| | Female | 1 | 14 | - | - | - | - | 2 | 29 |
| | Total | 5 | 71 | - | - | - | - | 2 | 29 |
| 73-96 | Male | - | - | - | - | - | - | - | - |
| | Female | - | - | 2 | 100 | - | - | - | - |
| | Total | - | - | 2 | 100 | - | - | - | - |
| 97-120 | Male | 1 | 25 | - | - | - | - | - | - |
| | Female | 2 | 50 | 1 | 25 | - | - | - | - |
| | Total | 3 | 75 | 1 | 25 | - | - | - | - |
| 120+ | Male | - | - | - | - | - | - | - | - |
| | Female | 1 | 100 | - | - | - | - | - | - |
| | Total | | 100 | - | - | - | - | - | - |

Table 1.7 Average Number of Hospitalizations by Gender and Length of Involvement

Clients with two and three hospitalizations were involved in the Hope Community Support Program for approximately one year less time on average than were clients with zero or one hospitalization. Subjects involved in the program for 49 or more months (N=14) averaged 0.64 hospital stays during the study period, while subjects involved for 48 or less months (N=24) averaged 0.75 days. Although the numerical difference is slight (0.11), this represents an increase of 15%. Subjects (all female) in the 49 to 72 month range had the highest average number of hospitalizations (2.0), followed by the

subjects (all female) in the 73 to 96 month range (1.0). The one client in the 120+ month range had the lowest average number of hospitalizations (none), followed by the clients in the 97 to 120 month range (0.25). Clients in the 73 to 96 month range also used the greatest number of hours per month (29.1). In general, clients involved 49 months and over used more service hours per month on average and had fewer hospitalizations, while clients involved 48 months and below used fewer service hours per month and had more hospitalizations on average.

One possible explanation for this is that subjects who used more service hours per month had more positive results, i.e., fewer hospitalizations, and therefore stayed involved in the program for longer periods of time. It is also possible that subjects remained in the program for longer periods of time because of an ongoing need for services. It may be that these subjects had had a higher number of hospitalizations during the early years of their involvement and were just now beginning to see the positive results of their continued involvement in the program. In other words, these subjects may have counted on the agency to help them maintain the progress they had made over the years.

Type of Service Involvement

Of the eight services provided, subjects used Benefits Assistance an average of 0.18 hours per month: males used an average of 0.35 hours per month and females used an average of 0.10 hours per month. Subjects used Client Outreach an average of 0.57 hours per month: males used 0.41, females used 0.64. The average amount of Crisis Assistance hours used per month was 0.11: for males it was 0.02 and for females it was

0.15 hours per month. Subjects used an average of 0.26 hours of Employment assistance per month, with males using 0.40 hours and females using 0.20 hours per month.

Housing assistance was used by all subjects an average of 0.31 hours per month, males using 0.37 hours and females using an average of 0.28 hours per month. The second largest service used by subjects was Independent Living Skills, with an average of 3.19 hours used per month. Males averaged 2.96 hours per month and females used this service an average of 3.28 hours. Subjects used an average of 0.18 hours of Medication Monitoring per month: males used an average of 0.10 hours and females used an average of 0.22 hours per month. The service used most by subjects was Psychosocial Rehabilitation, with males using 7.37 hours per month, females using 6.03 hours per month, and the average used by all subjects was 6.42 hours per month. (See Table 1.8).

| Service | Average Services Used Per Month | | |
|------------------------------------|---------------------------------|--------|-------------|
| | Male | Female | Total |
| Benefits Assistance | 0.35 | 0.10 | 0.18 |
| Client Outreach | 0.41 | 0.64 | 0.57 |
| Crisis Assistance | 0.02 | 0.15 | 0.11 |
| Employment | 0.40 | 0.20 | 0.26 |
| Housing | 0.37 | 0.28 | 0.31 |
| Independent Living Skills | 2.96 | 3.28 | 3.19 |
| Medication Monitoring | 0.10 | 0.22 | 0.18 |
| Psychosocial Rehabilitation | 7.37 | 6.03 | 6.42 |

Table 1.8 Average Services Used Per Month (In Hours)

Subjects with no hospitalizations during the study period used Benefits Assistance an average of 0.21 hours per month, Client Outreach an average of 0.58 hours, Crisis Assistance an average of 0.07 hours, Employment and average of 0.29 hours, Housing an average of 0.34 hours, Independent Living Skills an average of 3.32 hours, Medication Monitoring an average of 0.16 hours, and Psychosocial Rehabilitation an average of 4.51 hours per month. Subjects with one hospitalization during the study period used Benefits Assistance an average of 0.18 hours per month, Client Outreach an average of 0.40 hours, Crisis Assistance an average of 0.06 hours, Employment an average of 0.11 hours, Housing an average of 0.25 hours, Independent Living Skills an average of 2.91 hours, Medication Monitoring an average of 0.16 hours, and Psychosocial Rehabilitation an average of 13.75 hours per month.

Subjects with two hospitalizations during the study period used Benefits Assistance an average of 0.09 hours per month, Client Outreach an average of 0.40 hours, Crisis Assistance an average of 0.17 hours, Employment an average of 0.21 hours, Housing an average of 0.40 hours, Independent Living Skills an average of 2.14 hours, Medication Monitoring an average of 0.26 hours, and Psychosocial Rehabilitation an average of 5.69 hours per month. Subjects with three hospitalizations during the study period used Benefits Assistance an average of 0.08 hours per month, Client Outreach an average of 0.74 hours, Crisis Assistance an average of 0.36 hours, Employment an average of 0.33 hours, Housing an average of 0.23 hours, Independent Living Skills an average of 3.45 hours, Medication Monitoring an average of 0.32 hours, and Psychosocial Rehabilitation an average of 3.74 hours per month. (See Table 1.9).

| Number of Hospitalizations | | | | | | | | | | | | |
|-----------------------------|-----------------|--------|-------|-----------------|--------|-------|-----------------|--------|-------|-----------------|--------|-------|
| Service | 0 | | | 1 | | | 2 | | | 3 | | |
| | Ave. Hours Used | | | Ave. Hours Used | | | Ave. Hours Used | | | Ave. Hours Used | | |
| | Male | Female | Total | Male | Female | Total | Male | Female | Total | Male | Female | Total |
| Benefits Assistance | 0.46 | 0.07 | 0.21 | 0.07 | 0.24 | 0.18 | - | 0.09 | 0.09 | - | 0.08 | 0.08 |
| Client Outreach | 0.44 | 0.65 | 0.58 | 0.33 | 0.44 | 0.40 | - | 0.63 | 0.63 | - | 0.74 | 0.74 |
| Crisis Assistance | 0.01 | 0.10 | 0.07 | 0.03 | 0.08 | 0.06 | - | 0.17 | 0.17 | - | 0.36 | 0.36 |
| Employment | 0.50 | 0.18 | 0.29 | 0.14 | 0.09 | 0.11 | - | 0.21 | 0.21 | - | 0.33 | 0.33 |
| Housing | 0.47 | 0.27 | 0.34 | 0.09 | 0.34 | 0.25 | - | 0.40 | 0.40 | - | 0.23 | 0.23 |
| Independent Living Skills | 3.64 | 3.15 | 3.32 | 1.16 | 3.96 | 2.91 | - | 2.14 | 2.14 | - | 3.45 | 3.45 |
| Medication Monitoring | 0.10 | 0.19 | 0.16 | 0.12 | 0.18 | 0.16 | - | 0.26 | 0.26 | - | 0.32 | 0.32 |
| Psychosocial Rehabilitation | 4.69 | 4.41 | 4.51 | 14.52 | 13.29 | 13.75 | - | 5.69 | 5.69 | - | 3.74 | 3.74 |

Table 1.9 Type of Service Used: Average Hours Per Month

Clients with more hospitalizations used fewer Benefits Assistance service hours. It may be that this service was viewed by subjects as less important than services more closely linked with living independently in the community and reducing hospitalizations. All subjects used a greater than average number of Client Outreach hours per month with the exception of subjects with one hospitalization, who used fewer hours than the average. Subjects with two and three hospitalizations used more Crisis Assistance hours per month than the remaining subjects. One explanation for this is that these subjects needed more help planning for and working through crisis situations than other clients. Without knowing when subjects used these hours, either before or after a hospitalization, it is difficult to explain why this might be so. As with the average hours of all services used per month, an increase in Crisis Assistance hours may signify a hospitalization is about to occur, or the increase may be the result of a hospitalization.

Subjects with the highest number of hospitalizations also used higher number of Independent Living Skills hours per month. Again, when these hours were used is important. It is likely that an increase in the use of this service followed a hospitalization with the hope of teaching subjects the skills necessary to remain in the community. Subjects with the most hospitalizations also used more Medication Monitoring hours per month. Two explanations exist: one is that a hospitalization resulted in a medication adjustment and therefore the subjects needed more help to remain compliant with their medications. Another explanation is that subjects with difficulties in remaining medication compliant or with frequent medication adjustments have more hospitalizations.

Subjects with one hospitalization used more Psychosocial Rehabilitation hours per month. One possible reason for this is that subjects used more hours immediately following a hospitalization. Another way to look at this is that clients using more hours than the average have fewer hospitalizations. For example, subjects with two and three hospitalizations used fewer hours than average, although it is possible that with an increase in hours of this service the number of hospitalizations would decline. Subjects with no hospitalizations, however, also used less than the average amount of hours per month. It is possible that these subjects no longer need this service, or that they don't need as many hours of this service because they have fewer hospitalizations.

Although the majority of subjects appear to have benefited by their involvement in the Hope program, a number of subjects continued to have hospitalizations regardless of their length of involvement in the program and regardless of the type of services used or the amount of hours they used. It is possible that these differences are related to psychiatric diagnosis, age, marital status, or geographical location within the service area. For instance, subjects who live in the more rural areas may be more socially isolated resulting in a decreased ability to access other needed resources such as public transportation and/or medical/psychiatric care. This disjunction between the person and his or her environment is a primary focus of the ecological perspective, and an area that may need to be further addressed by clients and caseworkers (Libasi, 1988; Pardeck, 1996).

Another possible explanation for these differences lies in the variability among practitioners. In their evaluation of a comprehensive community rehabilitation program, Connors, Siddique, Van Vulpen, and Mulhall (1998) found that the relationship between

workers and clients was one of the most significant aspects of that program. Subjects in their study stated that "the trust they had built with" the practitioners "helped them in developing closer relationships with other clients and significant others" (Connors, Siddique, Van Vulpen, & Mulhall, 1998, p. 261). Caseload size may play a significant part in the delivery of services, as well as intangibles such as demeanor, empathy, and personality of the caseworker.

V. Summary and Conclusion

Strengths and Limitations

One possible limitation of the study lies in the area of reliability. It is possible that not all of the service usage data was entered appropriately in the agency database. Since the clients themselves report hospitalization data to the caseworkers, there exists the likelihood that this data may be under-reported or not reported accurately. Another limitation is that a large number of subjects are staying in crisis beds rather than going to a hospital. Again, subjects report this information to their caseworkers, and this is not done consistently by the subjects.

Since only those individuals who are currently utilizing Hope services are included, strength lies in the fact that there was no panel attrition. Another strength is that no survey instrument was used as data was reported using a simple frequency count. This research also lends itself to the possibility of conducting a longitudinal study of the subjects, which would help agency staff and clients determine if, when, and where progress has been made. The fact that this evaluation was conducted by a source outside of the agency also increases the strength of the research by reducing any biases that may arise had this evaluation been conducted by agency staff.

Recommendations

One important recommendation for the agency lies in gathering information on hospitalizations and the use of crisis beds. In several instances the case records indicated there had been a hospitalization, but the length of these hospitalizations was not known,

and for that reason this information was not included in the study. It would be very interesting to know if subjects were experiencing shorter hospital stays as well as a decrease in the number of hospitalizations. One reason this is important is that hospitalizations at regional treatment centers were counted as one hospitalization, even though these hospitalizations were of a much longer duration, and thus skewed the results possibly showing a better than usual outcome. It would also be useful to know when a hospitalization or the use of a crisis bed occurred in relation to when service usage increased or decreased. The information on when hospitalizations occurred was provided to the researcher, but was beyond the scope of this study. This information may possibly be crucial in indicating when a hospitalization is likely to occur.

Another recommendation is for the agency to compare differences among caseworkers. Comparing clients for each caseworker may show variability in type and amount of service usage as well as in the number of hospitalizations. Evaluating whether or not some caseworkers work better with certain types of clients (e.g., male vs. female, mood disorder vs. psychotic disorder, etc.) may assist in the assigning of clients to caseworkers better able to work with their particular and unique needs.

Practice/Policy Implications

As stated in the literature review, the implementation of the policy of deinstitutionalization of persons with mental illness has been a "dismal failure" (Whitmer, 1983). If the population of people with mental illnesses is to be given the best chances for success, there must be programs and resources in place to serve their unique needs. The Hope Community Support Program is one such resource. Research of similar

programs has shown promising results in increasing the quality of life of people with a mental illness (Lehman, 1998; Connors, Siddique, Vulpen, & Mulhall, 1998). The Hope program has not yet been systematically evaluated: if the results of this evaluation show it to be effective in helping people with a mental illness improve their quality of life by assisting them to remain independent in the community, it too can be a model for other programs. The components of this program may give others more tools and ideas for creating more resources for this underserved population.

Conclusion

As stated in the introduction, one of the primary goals of the Hope Community Support Program is to increase the quality of life of program participants through the provision of services aimed at reducing hospitalizations and increasing independent living skills. It is important to note that 61% (N=23) of the study sample did not have any hospitalizations during the 20-month study period. Another 21% (N=8) had only one hospitalization during that time. If one hypothesizes that a hospitalization occurred at the start of the study period, then the number of subjects with no hospitalizations could potentially be as high as 82%. Knowing the previous hospitalization history as well as when hospitalizations occur in reference to an increase or decrease in service use is an important area for future study.

Subjects who used higher numbers of service hours per month on average had fewer hospitalizations during the study period. There was also an observable relationship between type of services used and the number of hospitalizations: subjects who used a higher than average number of hours in the Client Outreach, Crisis Assistance, and

Medication Monitoring areas also averaged more hospitalizations. Subjects averaging more hospitalizations during the study period also used a lower than average number of hours in the Benefits Assistance, Independent Living Skills, and Psychosocial Rehabilitation areas. Subjects involved in the program between six and 48 months had 15% more hospitalizations than did subjects who were involved in the program for 49 or more months.

It appears from the results of this study that persons with a serious and persistent mental illness do benefit by their involvement in the Hope Community Support Program. The agency's use of an ecological framework allows practitioners flexibility in the work they do by enabling them to tailor services to best meet the needs of their clients. Viewing the environment as a resource for increasing the adaptive needs of clients allows for the building of support, while at the same time acknowledging that gaps do exist. By seeking to bridge these gaps along with their clients, caseworkers encourage them to reach their full potential and live as independently as possible in the community.

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December 13, 1998

Dear Mr. Randle:

As per our meeting and subsequent phone conversation, I am writing to you regarding the possibility of conducting an evaluation of the Hope Community Support Program for my graduate thesis.

I plan to conduct a quantitative research survey of clients who have been involved in your program over the past seven years. I will conduct a random survey of cases, sampling approximately ten cases from each year to collect data on service usage and hospitalizations to determine if there is a correlation between these two variables.

For this study, I will be reviewing case records only, and will not interview or survey any participants of your program. The Augsburg College Institutional Review Board (IRB) must approve any evaluation I conduct. These methods will not violate confidentiality or be harmful in any way to my research subjects. All reporting of data will be done in aggregate form.

I believe my research will benefit your program by helping to evaluate the effectiveness of the Hope Community Support Program. My evaluation will be an effective tool for determining which aspects of your program are most beneficial to the clients served. This evaluation may allow for the opportunity to continually improve services to best meet the program goals and the needs of the clients.

If you have any questions or concerns, please don't hesitate to contact me at the above address and/or phone number. Thank you for your consideration in this matter. I look forward to hearing from you at your earliest convenience.

Sincerely,

A handwritten signature in cursive script that reads "Lisa M. Powers".

Lisa M. Powers



HOPE COMMUNITY SUPPORT PROGRAM

January 22, 1999

Lisa M. Powers
107 Sherwood Manor
St. Cloud, MN 56304

Dear Ms. Powers:

This letter is to give you permission to conduct a program evaluation of Hope Community Support Program for your Master's thesis. As we've discussed, our program will work with you in compiling non-identifying data regarding a random sample of our clients that relates to level of service involvement and past psychiatric hospitalizations. Before publishing or making public any results from your research project, please understand that you will be required to obtain Catholic Charities' approval.

I look forward to working with you on this project. I think your proposal is an important area of research, and I'll do what I can to support your efforts.

Sincerely,

A handwritten signature in cursive script that reads "Greg Randle".

Greg Randle, Program Coordinator
Hope Community Support Program



709 2nd St. N., St. Cloud, MN 56303
(320) 259-0380 FAX: (320) 259-8761

Equal Employment Opportunity / Affirmative Action Employer

Augsburg College Institutional Review Board

REQUEST FOR APPROVAL FOR THE USE OF HUMAN SUBJECTS IN RESEARCH Social and Behavioral Sciences

1. **Project Title:** (use same title as grant application, if applicable)

Service Usage As A Measure of Program Effectiveness: One Agency's Experience

2. **Principal Investigator** Lisa M. Powers, MSW Candidate
(first mi last degree)

Telephone number 320-203-9122

College department name Social Work

Investigator's address 107 Sherwood Manor
St. Cloud, MN 56304

(For IRB Use Only)

Approval # _____

IRB Chair
(Signature)

Campus Box MSW _____

3. **Check one:**

Faculty / staff research

Fellow / post doctoral

Student Research

Undergraduate

Graduate

4. **If principal investigator is a student:**

Advisor's Name: Edward Skarnulis, Ph.D.

Address: Augsburg College
Dept. of Social Work

Telephone 612-330-1759

5. **Applications for approval to use human subjects in research require the following assurances and signatures to certify:**

- The information provided in this application form is correct.
- The Principal Investigator (PI) will seek and obtain prior written approval from the IRB for any substantive modification in the proposal, including, but not limited to changes in cooperating investigators, agencies as well as changes in procedures.
- Unexpected or otherwise significant adverse events in the course of this study will be promptly reported.
- Any significant new findings which develop during the course of this study which may affect the risks and benefits to participation will be reported in writing to the IRB and to the subjects.
- The research may not be initiated until final written approval is granted.

This research, once approved, is subject to continuing review and approval by the IRB. The PI will maintain records of this research according to IRB guidelines.

If these conditions are not met, approval of this research could be suspended.

Signature of Principal Investigator Lisa M. Powers Date 2-12-99

Student Research: As academic advisor to the student investigator, I assume responsibility for insuring that the student complies with College and federal regulations regarding the use of human subjects in research:

Signature of Academic/Thesis Advisor E. Skarnulis Date 2/12/99

Faculty/Staff Research: As department chair, or designed, I acknowledge that this research is in keeping with the standards set by our department and assure that the principal investigator has met all departmental requirements for review and approval of this research.

Signature of Department Chair _____ Date _____

MEMO

March 23, 1999

TO: Ms. Lisa Powers

FROM: Dr. Lucie Ferrell, IRB Chair

RE: Your IRB Application

I am writing in confirmation of the verbal IRB approval given you on March 15, 1999. Your study, "Service Usage as a Measure of Program Effectiveness: One Agency's Experience," has IRB approval number 99-22-2. Please use this on all official correspondence and written materials relative to your research. Would you please forward a copy of your data-gathering instrument to me to complete your application file.

Your evaluation should provide valuable information for the agency as well as for you. We wish you well in your endeavor.

LF:lmn

c: Dr. Edward Skarnulis

Dear Caseworker:


As you may know, I am required to do a thesis as part of my Master of Social Work education at Augsburg College. I have been approved to conduct an evaluation of your program (Institutional Review Board # 99-22-2), comparing service usage and hospitalizations in order to determine if increased service usage leads to a decrease in frequency and duration of hospitalizations.

I would like to thank you in advance for the extra work you are doing for me by gathering the necessary data. I realize this takes away from your other duties, therefore I am willing to help out any way I can. I have already spoken with Greg about the possibility of my coming in to help, so please let him know if there is anything I can do for you.

I am gathering data on gender, age, marital status, psychiatric diagnoses, and hospitalizations: service usage data will be collected for me from your agency's computer database. Please complete a form for each client as completely as possible. You may write on the backs of these forms if more space is needed. If you have any questions, I can be reached through Greg. I am asking that these forms be completed and turned in to Greg no later than April 5th.

I will be giving your agency a copy of my thesis once it has been completed and approved by Augsburg College. Again, thank you for your help!

Sincerely,

A handwritten signature in cursive script that reads "Lisa M. Powers". The signature is written in dark ink and is positioned above the typed name.

Lisa Powers