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ABSTRACT

This paper discusses the multiple roles sociologists play in conducting evaluation research in a large state psychiatric hospital. The key to understanding this form of clinical sociology is its blending of management and inquiry in a unique organizational context. The authors, sociologists who have both served as directors of the Buffalo Psychiatric Center's program evaluation unit since its founding in 1979, present examples of the unit's work, discussing the role sociologists play in the collection, analysis and reporting of data used by

hospital administrators for strategic planning, continuous quality improvement programs, and the monitoring of patterns and trends for census management, workload and staffing projections. The conduct of program evaluation and applied research in mental health care has been influenced by public policy, budgetary constraints, changes in national standards used in accrediting psychiatric hospitals, and the introduction of personal computers into the workplace. Several suggestions for improving the training of sociologists interested in this form of clinical practice are offered.

Introduction

For better or worse—and we think the latter—clinical sociological practice outside of academia is often perceived to be a distinct and even antagonistic enterprise when compared with scientific, pure, or academic sociology (Clark 1990; Fritz 1991; Straus 1991, 1992). In part, this results from academic sociologists' lack of knowledge about nonacademic research, and it is one of the goals of this paper to present a detailed image of a certain type of clinical sociology in place of the prevailing myths of nonacademic employment (Dowdall and Dowdall 1978; Kay 1978; Smith 1991).

The voluminous literature on program evaluation (e.g., Hargreaves, Atkisson, and Sorensen 1977; Lund 1978; Shortell and Richardson 1978) discusses in considerable detail the design and execution of applied research in health care settings. There is also an extensive literature about the management of health care institutions (for an exemplary text, see Shortell and Kaluzny 1988). What remains largely unexplored is the fusion of research and management into one form of practice that is fully sociological in substance yet takes place without bearing the formal title of sociology (Halliday and Janowitz 1992: 13–14).

We present an example of clinical sociology, defined in the 1992 mission statement of this journal as "the creation of new systems as well as the intervention in existing systems for purposes of assessment and/or change." We discuss how in-house program evaluation has been done by sociologists at a large state psychiatric hospital. Our case is a program evaluation unit which one of us founded and continues to direct, and in which the other acted as director for several years before returning to academic sociology. We examine applied research as practiced by sociologists in a state psychiatric hospital, discussing several factors that have shaped its practice. We conclude by suggesting that

graduate programs in sociology might take steps to prepare researchers for evaluation work in a management setting.

Sociology in Action: the Case of Psychiatric Hospitals

Because it represents the fusion of management with inquiry, evaluation research in state psychiatric hospitals turns out to be different from what one might imagine from reading the professional literature. Instead of a series of discrete research projects that evaluate individual programs, applied research in state psychiatric hospitals involves its practitioners in continuous discussion of program planning, management and evaluation issues, largely related to the quality of ongoing programs and the impact of management interventions and policy initiatives.

Working in a large psychiatric hospital, the sociologist operates in two roles—researcher and manager. As researcher, the sociologist uses the principles and methods of sociology to plan, monitor, and evaluate programs, collecting and analyzing data, formulating and testing hypotheses, and developing recommendations for corrective action. This work is most often done within the context of the hospital's quality assurance or total quality management (TQM) program (see Walton 1988). As a member of the management team, the sociologist uses the principles and methods of sociology to develop data collection, analysis and reporting systems to meet the clinical, programmatic, fiscal and policy-making needs of administration. This includes selecting indicators for monitoring performance, developing implementation strategies for new programs, and, as Lund (1978) has stated, "providing timely, reliable and useful data to program management to facilitate rational data-based decision-making."

The applied or clinical sociologist directs his or her work product to an audience largely made up of administrators and clinicians not formally schooled in the principles and methods of research. The sociologist must communicate findings, often based on aggregate analysis, to clinician/managers who, for the most part, have been taught to deal with issues in their profession on a case-by-case basis. Unlike the work product of the academic sociologist, the results obtained by the applied sociologist may not be generalizable and should not be full of disciplinary terminology and jargon (Lund 1978).

Like the sociologist working in market research or business consulting, the sociologist in this form of sociological practice does not carry the formal occupational title of sociologist (Straus 1991, 1992; also Halliday and Janowitz

1992: 13–14). Instead, New York State employs sociologists and other social scientists, particularly psychologists, as "program evaluation specialists."

Without the formal title of "sociologist," disciplinary concerns thus fade from immediate view while state policy and managerial goals and objectives come to the fore. In a similar fashion, Morrissey (1983; emphasis in original) used his experiences in the New York State Office of Mental Health's Special Projects Research Unit to argue that ". . . while *sociology* as a theoretical discipline may not always apply, the *work of sociologists* can and does make a difference in public and agency policy areas." His two examples show sociological research applied to policy decisions. Although involving the same state's mental health care system, our examples are not about statewide policy but about practice in a state hospital.

The Buffalo Psychiatric Center (BPC)

BPC is a large and complex state psychiatric center, serving a four-county area of western New York. It is one of several dozen facilities that the New York State Office of Mental Health operates across the state, providing psychiatric services to the severely and persistently mentally ill. Opened in 1880 as the Buffalo State Asylum and renamed the Buffalo State Hospital in 1890, it was given its present name in 1974 as part of the complex set of changes in policy and practice known as "deinstitutionalization." BPC has changed considerably from its earlier days as a custodial state hospital into a much smaller and more active center for psychiatric rehabilitation and treatment. (For more historical information and images of BPC's past, see Dowdall and Golden 1989; Dowdall, Marshall, and Morra 1990; Marshall and Dowdall 1982).

Both Mechanic (1989) and Gallagher (1987) have argued that sociologists have published little recently about the state hospital, but that it has in fact changed greatly from the image of the custodial hospital so vividly painted by Goffman (1961), Belknap (1956), and others. The recent history of the state hospital represents a fascinating chapter in the literature of organizational change. State hospitals are precisely the type of organization that one might predict would exhibit little or no change, since they are large, old, regulated by complex state law, and largely staffed by professional employees. But a unique confluence of state fiscal crisis, innovations in psychiatric and other clinical programs, management ideology, and personnel changes have produced profound organizational turbulence, which in turn has been a major factor in changing the character of sociological practice in state hospitals.

In 1991, BPC had 544 admissions and an average daily census of 481 (American Hospital Association 1991). With a staff of 1200, it operated programs for over 1800 outpatients and administered over 400 residential beds in the community. BPC is representative of the several hundred state psychiatric hospitals across the country that provide psychiatric rehabilitation and treatment to patients in need of intermediate and long-term care. BPC has been accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and certified by the U.S. Department of Health and Human Services.

BPC offers the following services:
- Inpatient Care
- Rehabilitation Services
- Day/Continuing Treatment
- Intensive Psychiatric Rehabilitation Training
- Case Management
- Intensive Case Management
- Psychosocial Clubs
- Screening and Evaluation Services
- Family Care
- Community Residence
- Residential Care Centers for Adults
- Sheltered Workshop

Blending Management and Inquiry

The BPC program evaluation unit was founded in August 1979. Since then, unit staffing has varied from two to seven staff. The overall size and consequently the amount and character of work unit staff performed has been influenced powerfully by several factors: 1) the changing nature of national accreditation standards for psychiatric hospitals; 2) the acquisition of personal computers for the workplace; 3) organizational turbulence produced by changes in policy, clinical practice and financing (c.f. Schinaar *et al.* 1992).

The work of program evaluation unit staff contains some elements that resemble the picture of evaluation research drawn in the research methods texts familiar to most sociologists (Babbie 1992; Hargreaves, Attkisson, and Sorensen 1977; Rossi, Freeman, and Wright 1979; Shortell and Richardson 1978). From the beginning, unit staff have participated in planning and evaluating numerous clinical interventions and innovations. They have collected and analyzed data for many of the hospital's risk management programs, identifying high risk patients

for followup, measuring the effectiveness of clinical interventions, and monitoring the quality of care. Unit staff monitor fluctuations in hospital census, number of admissions, discharges, and deaths, the use of restraint and seclusion, leaves without consent and escapes, patient falls, assaults, fights, fire setting, suicides, self abuse, accidental injuries, drug reactions, medication errors, allegations of patient abuse or neglect, and other patient-related incidents. They have conducted studies and developed programs to monitor decubitus ulcers and the effectiveness of clinical interventions designed to reduce their severity and rate of occurrence. They have assisted in the development of ward and unit staffing standards and have set up programs to monitor the use of overtime and unscheduled absenteeism. Unit staff have also demonstrated the importance of calculating age- and sex-adjusted incidence and prevalence rates in quality assurance programs where significant changes in indicators are often the result of changes in the size and profile of the patient population, not necessarily changes in the quality of patient care (Pinchoff and Caley 1991; Molnar and Pinchoff 1992).

Caley and Pinchoff (1991) present one example of a special project unit staff undertook as a pilot site to evaluate an innovative restraint and support system for the NYS Office of Mental Health. In presenting their findings, they discuss the questions mental health professionals might address in order to ensure that product evaluations are carried out safely and in a cost effective manner, and produce results useful to patients, clinicians, and administrators.

For the most part, however, the unit's output has consisted of a series of regular and special reports distributed within BPC administration. Perhaps the most important of these is a monthly unit report which presents a series of graphs, tables, and brief written analyses of the most important trends in BPC's inpatient census. These reports provide the empirical data that is used in day-to-day management and in strategic planning activities.

While planning and evaluating innovations have been an important source of activity for unit staff, in many ways BPC program evaluation unit staff have expanded their role primarily through involvement in the day-to-day management of this large mental health care organization. Perhaps the most striking divergence from the model of evaluation research in the literature has been its participation in the internal reorganization of the psychiatric hospital and its top management team (Pinchoff and Mirza 1982). In this context, unit staff continue to play a major role in the collection, analysis, and reporting of data used by hospital management for strategic planning, continuous quality improvement programs, and the monitoring of patterns and trends for census management, workload, and staffing projections.

Accreditation: The Impact of the Joint Commission

Among the most important factors setting the content for the program evaluation unit's work is external oversight. A modern state psychiatric hospital operates in a highly institutionalized organizational environment, in which organizational conformity to professional, political, and regulatory norms powerfully shapes everyday organizational life (Powell and DiMaggio 1991).

As the standards-setting agency for hospital accreditation in this country, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), formerly the Joint Commission on Accreditation of Hospitals (JCAH), has been a major factor in changing the type of work produced by program evaluation unit staff. It has been the policy of New York State that all of its psychiatric centers be accredited by JCAHO, just as most hospitals and healthcare centers in the United States are. Moreover, JCAHO accreditation is a prerequisite for reimbursement by federal and private insurance systems. Standards in the late 70s and early 80s (e.g., JCAH 1981) included a separate chapter that mandated program evaluation, defined as facility-wide planning of goals and objectives and organized evaluation of accomplishments. In response, program evaluation unit staff focused on this type of centralized, in-house planning and evaluation. But during the 1980s, JCAH shifted toward a more decentralized system of planning and evaluation, with individual clinical units and disciplines seeking to pursue what was variously referred to as "Quality Assurance," "Continuous Quality Improvement" (CQI), or "Total Quality Management" (TQM). CQI and TQM both reflect the ideas of arguably the most important theorist of quality management, W. Edwards Deming, and have been employed in many industries, including manufacturing, health care, and education (Walton 1988). The program evaluation unit has evolved into an in-house source of consultation for planning, evaluation, and research.

JCAH (1981: 31; emphasized in original) standards defined program evaluation as "... a management tool primarily utilized by the hospital's administration to assess and monitor, on a priority basis, a variety of facility, service, and programmatic activities." Chapter 8 presented two broad standards. The first required the facility to develop written goals and objectives, based on the needs of the population served. It required a "written plan for evaluating its progress in attaining its goals and objectives," with annual evaluations and revisions provided to the governing body, administration, and staff. The second called for "documentation that the findings of the evaluation have influenced facility and program planning."

The 1981 JCAH manual also called for a facility-wide program of quality assurance "designed to enhance patient care through the ongoing objective assessment of important aspects of patient care and the correction of identified problems" (JCAH 1981: 33). A cycle of decentralized problem identification, assessment, correction, and monitoring was mandated by the standards, with focus on clinical care.

In response, unit staff changed their roles, functioning more in the role of technical consultant, providing assistance to clinical department heads in their new-found and, for the most part, unprepared and unwanted role as "researchers." Program evaluation at BPC has evolved over a relatively short period of time, changing in part because of the changing external standards, in part because of the kinds of projects the unit has taken on and in part because of the computer competence of its staff and the great growth in computing at BPC.

The best way to discuss how the work of program evaluation unit staff at BPC has evolved is to examine representative summaries of activities in three different years (Buffalo Psychiatric Center 1981, 1985, and 1992). The common threads running through these examples are the requisite skills of the sociologist: knowledge of the scientific method and computer competence, including: how to design a study, formulate hypotheses, draw a sample, collect and analyze data, manage and manipulate large databases, conduct statistical tests of significance, make inferences, draw conclusions, identify associations and causal relationships. These skills are needed and valued by management in an environment that values rational data-based decision making.

Computing and Statistical Expertise

An early project illustrates the fusion of management and inquiry and shows how the actual work of a clinical sociologist makes use of the same methodological skills as the academic researcher. Using a mainframe statistical package, SAS, the unit staff developed a Personnel Management Information System (PMIS). Every two weeks (to coincide with the hospital's payroll), unit staff would receive from the personnel department notice of which employees had been appointed, terminated, or placed on leave. This information was then used to update a data file of 34 different elements for each personnel line. Over two hundred job titles described the work of the 1200 employees. SAS programs were developed to generate reports that described the staffing of each of the administrative, clinical, and support units. This enabled the personnel department and hospital adminis-

trators to monitor the allocation of personnel resources by administrative or treatment unit and by staff title, e.g., physician, nurse, therapy aide. Unit staff developed other reports such as racial and gender profiles of the staff, useful for addressing affirmative action questions. The PMIS proved extremely useful in the day-to-day management of the hospital, drew on the research skills of the sociologists in the unit, but had virtually no connection to the types of work that make up the image of evaluation research in published sociology.

Competence in computing led unit staff to serve for some time as in-house consultants on the use of personal computers, the statewide patient information system, and other Albany-based mainframe applications. Computer competence has meant that unit staff have played a significant role in providing and interpreting data for management. Again, these activities bear little relation to published work in evaluation research, but were of significant value to BPC management. They became part of the basic expectation held by management for unit staff.

A major part of the work of program evaluation unit staff consists of using these skills to help plan and evaluate the effectiveness of clinical programs, with a particular emphasis on helping administrators and clinicians select indicators of performance which can be used to monitor and improve existing clinical programs. Recent attention in this area has been directed at the use of outcome measures with an emphasis on risk management and total quality management programs. Thus, program evaluation staff recently developed a database to monitor the extent to which variations in 30-day readmission rates are associated with changes in discharge medication prescribing and dispensing practices, controlling for age, sex, race/ethnicity, severity of illness, and type of psychotropic drug. Analysis of this database will help to identify issues of clinical significance and quality of care. Other examples of the unit's work include the development of a database for the drug use evaluation committee to identify patterns and monitor trends in medication practices of individual physicians and patients; use of customer satisfaction surveys as part of BPC's TQM program; and, most recently, participation in a national study to test the efficacy and safety of a new psychotropic medication to treat schizophrenia.

Conclusions and Recommendations

Sociologists employed in program evaluation in state psychiatric hospitals work under civil service job titles that are functional rather than disciplinary. At a time when sociologists are concerned about their "fragile professionalism" (Halliday and Janowitz 1992), working as an applied or clinical sociologist but

with a job title that masks one's disciplinary roots poses some major challenges of long-term professional identity. That these are also faced by those program evaluators drawn from other disciplines such as psychology or nursing does not lessen the problem, though it suggests some interesting lines of inquiry about how bureaucratic roles shape professional identity. We think that too little attention has been paid in the professional sociological literature to this question of professional submergence and identity.

But we have several concrete suggestions for those interested in this type of activity. A solid background in statistical analysis (of survey data and small-N analysis), probability and sampling techniques, qualitative and case analysis are prerequisites for the type of research we describe here. Also necessary are broad research design skills (especially for applied and evaluation research), survey research skills, some understanding of public management and budgeting, and substantial experience in health or mental health care (particularly in the principles of epidemiology and biostatistics) and hospital administration (Shortell and Kaluzny 1988). Finally, program evaluators need a solid background and a willingness to keep up with advances in computing and data processing, particularly using microcomputers. While most positions in program evaluation will require graduate training, entrance-level jobs have existed, and undergraduate applied or clinical sociology program faculty might well ponder how to match their programs with state job requirements (Ballantine 1991; Schutt and Costner 1992).

Methodological training in academic sociology has tended to emphasize the collection of new data, particularly survey data (Reiss in Halliday and Janowitz 1992). But the most useful program evaluation in state hospitals often takes the exact opposite form, using data collected by clinicians in the course of their practice to shed light on patterns of care. Sociologists can help improve the collection of data for monitoring the performance of clinical programs by providing technical assistance and consultation to clinicians and administrators in: 1) the use of sampling techniques, study design and statistical testing; 2) the selection of valid and reliable indicators of program quality and performance; and 3) the use of computers to manage databases and prepare reports.

However, it is not enough for sociologists interested in this form of practice to be familiar with evaluation research methodology. If practice is actually determined by the specific organizational context of the state psychiatric hospital, adequate preparation must include familiarity with other issues. An appreciation of the recent history of the state hospital and public mental health care might help in developing the flexibility needed to work in state government (Morrissey *et al.*

1980). Both broad public policy questions (Hudson and Cox 1991; Rochefort 1989) and state psychiatric hospital clinical practice and management issues (Treanor and Cotch 1990) should be examined. Regular reading of such journals as *Hospital and Community Psychiatry* and *Administration and Policy in Mental Health* would give insight into the perspectives of clinicians and administrators. Moreover, appointment to program evaluation positions requires detailed knowledge of state civil service procedures and examinations (see Appendix A), as well as requisite experience and/or educational requirements.

Finally, to function successfully in the role of a program evaluation specialist in a state psychiatric hospital, sociologists (and those from other academic disciplines) must be willing to mute their exclusive disciplinary identities in favor of participating in a management team. But traditional graduate training often leads to just the opposite—the importance of disciplinary identity. While this is no doubt functional for the majority of graduates who will go on to work in sociology programs, graduate programs should also provide some orientation to those who will venture into nondisciplinary positions.

Sociologists who want to engage in this form of practice will find professional challenges and personal rewards. Being a sociologist/program evaluation specialist in a state hospital can mean seeing the results of one's research actually put to use quickly, rather than having yet another report sit unused on a manager's dusty bookshelf (Goldstein *et al*. 1978). One of the most important rewards of this activity is being able to use one's professional knowledge and training to help in dealing with one of society's most enduring social concerns, the care and treatment of the seriously mentally ill.

Appendix A

Appointment As Program Evaluation Specialists

In the late 1970s, appointment to these titles was done by reviewing the professional credentials of the applicants, and then evaluating how much experience a candidate had. A few years later, a standard civil service examination was used to generate scores which, when combined with an assessment of experience, were used to place a particular individual on a statewide list. (Extra credit was given if the candidate had served in the armed forces.) Following standard practice, an individual facility that wished to hire a program evaluation specialist of a given rank had to interview at least the top three candidates then available from this list, and then could choose from among these three.

The four program evaluation specialist positions (Grades I to IV) differ significantly in their experience requirements, duties, and salaries. Qualifying experience to take the exam at different levels includes a combination of educational degree with direct program evaluation experience in mental health, mental retardation, developmental disabilities, substance abuse, alcoholism, public health or college or university teaching in a related field, and/or mental hygiene clinical practice or administration. For appointment to Grade IV, at least a year in an administrative or supervisory capacity as well as an oral exam administered in Albany were added to the written exams given to all levels.

We present these details because this type of information is rarely if ever published in professional publications in sociology. Yet without this information, even the most highly qualified social scientist would simply be ineligible for appointment. Position announcements are available from the New York State Department of Civil Service.

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