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ONE SYSTEM, MANY PERSPECTIVES: STAKEHOLDERS AND MENTAL HEALTH SYSTEM EVALUATION

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ABSTRACT

The use of an action research model to integrate the perspective of multiple stakeholders in the evaluation of a state's mental health reform is described. The process of forming the evaluation team (a mix of university and state legislative staff) is addressed in the context of the political and scientific nature of public systems evaluation. A brief description of action research and its role in program evaluation provides the basis for discussing how the principles of action research were incorporated into the study, from the definition of research questions, to sampling, measurement, analysis and dissemination.

TEAM FORMATION AND PROPOSAL DEVELOPMENT

The legislation specified that an evaluation plan be submitted to the legislature by December, 1990 with the report to be submitted by December, 1992. The Legislative Budget Committee (LBC) contracted the two University of Washington (UW) faculty who became the principal investigators in November of 1990 to explore interest in having the UW conduct the "client outcome" portion of

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the study while LBC conducted a "process" evaluation of whether the legislative mandates had been implemented. The UW principle investigators assembled a team of 9 faculty, 4 core staff and several students from psychiatry, social work and nursing to develop a proposal in collaboration with LBC. The proposal was submitted in February, 1991. Although scheduled to begin in July, 1991 with pilot testing, legislative and bureaucratic delays in funding resulted in the project not being initiated until late summer with the project director being hired by September 1, 1991. Thus, by the time human subjects approval and funding were established, the study needed to be completed in 14 months.

POLITICAL AND SCIENTIFIC CONTEXT OF PUBLIC SYSTEMS EVALUATION

A conference report sponsored by the National Institute of Mental Health (NIMH) that appeared the same year that SSB5400 was funded included the following prescient description of the status quo:

> Public mental health systems also have had difficulty defining the outcomes they seek and communicating the effects made by their service interventions. Most state mental health systems have not determined how their successes are to be defined, measured and communicated to the public at large. Only by making such determinations can we expand and replicate the exemplary practices that are at the forefront of change in public mental health. (Mauch & Morrison, 1989, pp. 15–16)

While 5400 included several explicit and implicit "goals," there had been no discussion in formulating the bill, or prior to its implementation, about how stakeholders could know if these goals (or any others) had been achieved. Thus, in a little more than a year, the project had to both interpret these goals of the legislation and decide how they could be measured using data (e.g., agency records) that had not been created for evaluation purposes.

LEGISLATIVE BUDGET COMMITTEE AND UW COLLABORATION

Furthermore, the study involved both an untried collaboration between LBC and UW researchers and would be of interest to a variety of people beyond the legislative body that commissioned it. While LBC had previously commissioned studies from the UW and had conducted many of their own evaluations, this was the first time a truly "collaborative" approach was undertaken. Under the time pressure of completing a complex study with significant political and funding consequences, conflicts and misunderstandings arose with some frequency and required time to resolve. While a longer lead time might have prevented some, most were probably inevitable components of newly formed working teams and were as often as not productive. Certainly neither group alone could have produced as comprehensive and well documented a report within the temporal and political constraints. The final report to the legislature combined both efforts into a single, well integrated analysis.

MULTIPLE STAKEHOLDERS, PROGRAM EVALUATION AND ACTION RESEARCH

Social science research, especially that directed toward public policy, has significantly altered the views of research that originated from the natural sciences (Lash, 1990; Cook, 1985; Bhaskar, 1989; Fiske & Shweder, 1986). Among other key insights is recognition that all research is a form of rational persuasion and that its form and content varies with the audiences being addressed (Bernstein, 1988; Popkewitz, 1984). This is even more true of program evaluation research and introduces the question of what *types* of evidence will be most persuasive to the audiences that will be interpreting the results (Harding, 1991; Fiske & Shweder, 1986; Chronbach, 1980). Thus discussions of the use of statistical, case study or interview data are shaped not just by the nature of the research questions, but by the anticipated consumers of the research (Fonow & Cook, 1991). Who would be most concerned about the quality of statistical data? Who would dismiss a nonexperimental design? Who would require access to the words of actual consumers and doubt the validity of any aggregated data? Who would require context-specific information and who would demand system-wide generalizations? What is the best balance that can be achieved among these conflicting expectations?

Discussions about types of evidence/data to pursue are also affected, especially in limited time frames, by the practical and political accessibility of the data. For example, system wide demographic and clinical data was held by the Mental Health Division (MHD) and individual client charts were held by agencies. Both had a definite (and not necessarily compatible) stake in the outcome of the evaluation; both feared any data would be used "against" them in the struggle over limited resources and both distrusted to some extent the data provided by the other.

A frequent result of ignoring the real programmatic, scientific and political realities sketched above is that public systems evaluations become the target of conflict as various parties argue about the nature of the study and the quality and meaning of the data and analyses produced. Instead of arguing about substantive issues—what facets of programs are meeting what goals—and using the evaluation as data for resolving these substantive disagreements, the evaluation gets snared in the debates and becomes a political football.

Action research, a generic term with multiple definitions, has emerged out of these scientific and political contexts (Lather, 1991). Defined broadly as "the systematic gathering of information by people who are both affected by a problem and who want to solve that problem" (Rubin & Rubin, 1986, p. 157), most action research programs are "joint efforts of concerned professionals and clients or consumers of services" (Wagner, 1991, p. 477). Action research was originally based in political philosophies that emphasized "bottom-up" approaches designed to advance the interests of less-privileged groups such as literacy programs for peasant populations articulated by Paulo Friere (1973). It evolved from the perception that the values and interests of much research, while apparently "neutral," actually reflected the more limited commitments of key governmental and professional groups (Harding, 1991). The field has more recently expanded through the works of feminists and others committed to balancing the power of traditional centers of scientific legitimacy which have often been seen to work counter to the self-interests of women and people of color (Fonow & Cook, 1991; Maguire, 1987; Lather, 1991). In clinical fields this has, of course, included consumers of mental health services and their families (Fransen, 1991; Fernando, 1989; Kleinman, 1988, 1980).

Action research programs are characterized by heterogeneous research groups, usually a blend of citizen "representatives" of disenfranchised populations who are "experts" with respect to participating in (or being ignored by) the system being researched and sympathetic "professionals" with clinical and research expertise. The purpose is to create evaluations that adequately reflect the goals and experiences of service recipients (in addition to other constituencies) by involving them directly in the design, conduct and dissemination of the study. Such studies often employ more "grounded" analyses that remain closer to the experience of consumers. Distrust of the manipulation implicit in experimental design (and a frequently accompanying view of human behavior as purely effects) and of the generalization and context-stripping involved in quantitative instrumentation has led many, but by no means all, studies to be more inductive and interpretive in nature. But with increasing recognition that information plays a limited role in political decision making, policy-oriented action research has expanded to include other key players such as funding source, providers, bureaucrats, etc. From another perspective, Thomas Cook (1985), in describing "multiplist" and heterogeneous approaches to science, has noted that:

> In a democracy with pretensions to pluralism, formal policymakers should probably not be the only group whose information needs, and hence whose political interests, evaluators should meet. Every policy decision has the potential to impact on multiple stakeholder groups, and discussions with these groups often teach us that they want to learn different things. (p. 481)

While, as noted earlier, the short time frames required submission of a fairly detailed research plan that didn't evolve from input by multiple stakeholders, the general research approach was shaped by an action orientation.

STAKEHOLDER IDENTIFICATION AND INVOLVEMENT

Recognizing that "consumers and their families form a vital link in the growing coalition of providers, planners, recipients and advocates committed to making community services more responsive and effective" and that "the work of each of these constituencies in 'keeping the faith' has been the single most important force for change in the current mental health system," (Mauch & Morrison, 1987, p. 18), a decision was made to implement a modified form of action research. We approached the challenges of multiple stakeholders who held unclear and perhaps incompatible goals for mental health reform by trying to incorporate as many of them as possible into the study itself. Strategies for obtaining multiple perspectives included: a) formation of an advisory panel; b) negotiation among team members; c) interviewing and making presentations to influential groups; d) deciding who should be interviewed; e) maintaining a positive working relationship with the MHD; f) managing dissemination of the evaluation.

In this section, each of these strategies will be reviewed and their strengths and limitations assessed.

A. Advisory Panel

As part of our proposal to the legislature, we recommended formation of an advisory panel (see Appendix) that included the most important groups concerned about mental health reform, although clearly not all individuals. We recruited members from consumer and family groups, as well as providers, regional service networks, the MHD, state hospitals and various legislative and governmental members (including two involved in drafting the original legislation). In addition, while we were forming the panel, several of us met with key legislators and asked their advice about: a) how to make sure the final report was policy and legislatively relevant and b) any stakeholders they thought we should include in the panel. We also visited influential groups such as Advocates for the Mentally Ill, the Division's Ethnic Minority Advisory Council, groups of providers and RSN representatives and others to explain the process for the study, solicit input and recruit panel members. The LBC also recommended members.

Our goals for the Advisory Panel were complex. We wanted: a) to build a political constituency for the evaluation itself; b) groups who disagreed about the goals of mental health reform to both have equal acess to the data and to help identify data that would be meaningful to them; c) to augment input from LBC with broader legislative and policy perspectives; d) practical and political advice about how to conduct the study with the severe time limits; e) help analyzing the data to balance our own blind spots and frame interpretations in a larger context of what was happening in the state; f) to anticipate, surface and possibly mediate conflicts in the course of the evaluation rather than have them arise during legislative discussions of the evaluation. For example, there were strongly held views about whether there would be enough or too much emphasis on ethnic minority groups and conflicting interpretations of the "intent" of the legislation itself (e.g., to improve care, reduce state hospital costs, increase access to care).

The Advisory Panel met 8 times over a 1-year period, with monthly meetings at the beginning and end of the period and quarterly meetings during the data collection phase. In addition to UW and LBC members, there were usually 10–15 members present. Predictably, attendance varied with the issues to be discussed, but a broad spectrum of interests was consistently represented. While the meetings proved a challenge to manage due to the strongly held positions of forceful individuals, they largely served the purposes for which they were intended.

For example, one political and scientific challenge had to do with the inclusion of people of color in the sample. Having both a history of under-representation and uneven treatment (Fernando, 1989) and being specifically addressed in the legislation, it was critical to include them. But the question became, who were they? Some Panel members were vociferously opposed, suggesting that Norwegian farmers weren't being separated out, so why should Hispanics? On the other hand, Washington has a rich and varied mixture of people of color, including a variety of Asian backgrounds, reservation and non-reservation dwelling Native Americans, Hispanics and African Americans. The Panel advised us to meet with the MHD's Ethnic Advisory Council, which we did. The Council quickly agreed it would not be feasible to include all groups in the short time frame and limited resources of the study and recommended we focus on urban African Americans and rural Hispanics. The Advisory Panel agreed and this issue was largely put to rest for the duration of the study.

The Advisory Panel provided similarly vital advice concerning which Regional Service Networks (RSNs) to include in the sample as well as which providers or subregions to make sure we covered. In addition, as initial results were reported, they both raised questions about further analyses that would clarify interpretation (e.g., on how to determine if the most seriously mentally ill persons were receiving the most services) and on situational factors that influenced results (e.g., the over-representation of older adults in one RSN being related to specialized programming and state hospital contracts). These recommendations substantially improved the quality of the information and successfully anticipated questions that might have undermined the reception of the evaluation.

Unfortunately, the composition of the Panel was "typical" in one critical respect: consumers and family members were under-represented and the Panel was dominated by governmental and provider members. Furthermore, it was only constituted after the original proposal was funded, and thus wasn't involved in some crucial, early design decisions.

B. Negotiation Among Team Members

Each team member brought both individual research strengths and disciplinary perspectives (as well as personalities!) to the project. Considerable effort was devoted to dividing responsibilities to capitalize on these strengths, assuring relatively uniform progress in accomplishing tasks under a very constrained time line, coordinating input into both process and substantive questions and maintaining cohesion. As just one example, there were extensive discussions about the nature of the ethnographic component, its role in answering questions and its scientific validity. Similarly, analytic decisions about the types of data provided in the MIS data tapes, the use of a client functionality measure and supervision of chart reviews all surfaced significant differences of opinion. These normal differences were amplified by the problem of a complex study which both depended upon timely completion of tasks and yet lacked a line-relationship among participants. The key to successful negotiation of team issues was the hiring of an extremely strong, experienced project director who had faculty status. Since the two principle investigators had demanding administrative appointments and were unable to provide the daily supervision and tracking required, the study would have foundered with a less talented director. At times, there are no process substitutes for strong personnel!

C. Interviewing and Presenting to Stakeholders

Any evaluation sponsored by and reporting to the primary funder of a system inevitably raises anxieties about how the report will be used. Investigators met with several state senators, representatives and their staff to get their perspectives on what constituted a policy-relevant research report and hear any concerns they had about the proposal. We also met with groups of stakeholders to familiarize them with the process of the study, solicit Advisory Panel members and hear concerns. These included various boards that advised the MHD and statewide groups of system administrators and providers as well as advocacy groups. As a result of these contacts, we had positive working relationships throughout the study and when we solicited feedback on reports of the draft and when LBC received formal responses to the report, these were very constructive.

D. Maintaining a Positive Working Relationship With MHD

The MHD had one of the biggest stakes in the outcome of the evaluation as they were charged with implementation of 5400. Furthermore, they were in daily contact with all levels of the mental health system and were collectors and repositories for the Management Information System data base. We were concerned to conduct a study that they felt was fair and thorough and to maintain collaborative relationships that were important for the study (e.g., to expedite access to data) and afterwards (since all the investigators had ongoing commitments to the state's mental health system). Thus we invited them to sit on the Advisory Panel; we met with them prior to and during the study to get their feedback and, with LBC, presented preliminary drafts to get their feedback. At the same time, we maintained the integrity of the study through use of both the Advisory Panel and control over the data and its analysis. Consequently, we encountered no resistance to conducting the study and received active cooperation when it was requested. In the short time-frame we had, a positive relationship was essential.

E. Dissemination of the Study

While we depended upon Advisory Panel members to keep their various constituencies advised of the study's progress, as we neared completion we held a joint meeting of both the Advisory Panel and RSN provider representatives to preview the study results and obtain feedback about clarity and fairness of presentation. We also envisioned this as a form of "rumor" control since the official report wouldn't be available until a legislative review had been completed. With an approaching legislative session, rumblings about state budget deficits accelerated concerns. Needless to say, we had significant attendance at the meeting and the feedback was positive.

CONCLUSION

The multi-disciplinary nature of the study team and the University–LBC collaboration provided a broad range of perspectives on mental health system evaluation. Efforts to broaden those perspectives and to build an effective coalition through formation of an Advisory Panel and an action-research orientation were largely effective, as later sections will attest. The quality of the study was significantly enhanced by this participation and we avoided unnecessary expenditure of limited time on internecine conflicts through the range of strategies we employed.

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APPENDIX: ADVISORY PANEL COMPOSITION

Washington Advocates for the Mentally Ill (WAMI)
Alliance for the Mentally Ill (AMI)
Community Action for Mentally Ill Offenders (CAMIO)
Eastern State Hospital
Western State Hospital
Mentally Ill Consumers
House of Representatives: Appropriations and Human Services Committees
Senate: Health & Long Term Care, Ways & Means, Democratic Caucus
Regional Service Networks
Community Mental Health Providers (Agencies)
Washington State Division of Mental Health
Washington State Office of Financial Management
Washington Community Mental Health Council