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METHODOLOGICAL CHALLENGES IN EVALUATING MOBILE CRISIS PSYCHIATRIC PROGRAMS

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Abstract: Mobile crisis psychiatric programs (MCPPs) are innovative community interventions that have gained acceptance in the health, social, and political environments. In Canada they are becoming widely implemented, and the need to evaluate them is pressing. Unfortunately, there has been very little formal evaluation of them and virtually no data on their effectiveness. Part of the reason for this deficiency may be the methodological challenges inherent in these programs. In this article, we discuss these difficulties by examining the integration of these programs within the service delivery network and offer suggestions for future evaluative research.

Résumé: Les programmes mobiles d'intervention psychiatrique d'urgence (MCPP) sont des initiatives communautaires innovatrices qui ont gagné leurs lettres de noblesse dans les milieux de la santé, sociaux et politiques. Au Canada, ils sont de plus en plus répandus et il devient primordial de les évaluer. Malheureusement, ils ont fait l'objet de très peu d'évaluations officielles et il n'existe presqu'aucune donnée sur leur efficacité. La raison de cette lacune est en partie la difficulté méthodologique inhérente à ces programmes. Cet article traite de ces difficultés en examinant l'intégration de ces programmes dans le réseau de prestation des services et suggère des formules de recherche évaluative pour l'avenir.

A number of recent initiatives within Canada have attempted to provide principles and goals to guide reform of the men-

tal health system (CMHA, 1998). The consumer has been placed at the centre of the mental health system, with services being tailored to consumer needs, and improved linkages and coordination established between the community and hospital sectors. Mobile crisis psychiatric programs based on best practices are an important component of the proposed comprehensive service continuum. In Canada, these services are widely implemented, making it necessary to consider ways to evaluate their effectiveness.

Mobile crisis psychiatric programs (MCPPs) are popularly viewed as responsive and humane approaches to aiding people with significant mental health disorders. There have been several studies, mostly descriptive, about the benefits of individual MCPPs (Bengelsdorf & Alden, 1987; Bengelsdorf, Church, Kaye, Orlowski, & Alden, 1993; Bigelow, Sladen-Dew, & Russell, 1994; Fisher, Geller, & Wirth-Cauchon, 1990; Gillig, Dumaine, & Hillard, 1990; Lamb, Shaner, Elliott, DeCuir, & Folz, 1995; Reding & Raphelson, 1995, Zealberg, Christie, Puckett, McAlhany, & Durban, 1992; Zealberg & Santos, 1993). Several of these studies address whether service recipients were able to remain in the community (Bengelsdorf & Alden, 1987; Bigelow et al., 1994; Gillig et al., 1990). The results show that overall the MCPPs do seem to prevent some hospitalizations; however, because these programs identify individuals who might not otherwise have been treated, the overall hospitalization rate may not be lower.

In 1997 a Canadian review of best practices in mental health reform was published that reviewed research evidence and key elements for various core mental health services (Health Systems Research Unit, Clarke Institute of Psychiatry, 1998). With respect to crisis response, the group said that non-experimental and descriptive studies suggest that crisis housing provides a viable alternative to hospitalization, diversion programs are effective, and crisis centres can serve persons with psychosocial problems. Key elements of best practice in crisis response included establishing services using minimally intrusive options, diverting people from inpatient hospitalization, and incorporating evaluation/research protocols into crisis programs.

Important though these non-experimental and descriptive studies are in understanding MCPPs, to date there have been no multi-site evaluations of MCPPs, and the generalizability of the studies has been limited. This situation led Geller, Fisher, and McDermeit (1995) to express concern that anecdotal evidence is being used to make

decisions about these interventions. There has been very little formal evaluation of them, and virtually no data on their effectiveness (Geller et al., 1995). Effectiveness studies would demonstrate the extent to which MCPPs, when deployed in the field in routine circumstances, do what they are intended to do for the specified target population. For these programs, the usual target population is adults with persistent and severe mental disorders (e.g., schizophrenia, chronic mood disorders) as well as a range of socially and economically significant mental disorders (anxiety disorders, acute depression, substance abuse). Geller et al. propose that efficacy studies be done that clearly specify the target population, describe the team format and the nature of the mobile intervention, make cost comparisons with service alternatives, and provide follow-up and outcome data.

Part of the reason for the lack of efficacy and effectiveness evaluations may be the methodological challenges inherent in these programs. This article discusses these methodological problems and provides some strategies for addressing them, strategies based on our recent experience in evaluating two community-based mobile psychiatry programs (http://www.ontario.cmha.ca/cmhei). Table 1 outlines the challenges and possible strategies to deal with them.

METHODOLOGICAL ISSUES

Integration of MCPPs

Unfortunately, the generic label of "MCPPs" is often used although the programs may differ substantially in their organizational structure, components, and activities. Some programs exclude certain types of patients (e.g., those who may be imminently suicidal or homicidal), and others target services to these and other high-risk groups (e.g., substance abuse, severely and persistently mentally ill, homeless). Many have a roster of individuals who receive the services if needed and when it is available; some have no predetermined listing. Some programs operate 24 hours a day; others have restricted hours. Their structure may also differ. For example, some use police as back-up (Gillig et al., 1990), include psychiatric consultation (Bigelow et al., 1994; Zealberg et al., 1992; Zealberg & Santos, 1993), or partner with social services (Bengelsdorf & Alden, 1987; Bigelow et al., 1994), whereas others do not.

MCPPs are community outreach programs where the goal may not be primarily clinical, but service integration. As MCPP clients need

a number of services in addition to the community outreach, many MCPPs become integrated with other services and programs. Consequently, these programs may be housed with social services, community or hospital assessment, and treatment services. Although some MCPPs provide only emergency interventions and will refer clients to others for ongoing support services (e.g., stand-alone programs), many others provide this support themselves (e.g., integrated programs). Even in stand-alone programs, however, MCPPs develop partnerships of one kind or another to facilitate referrals although they are not formally linked to these services.

Table 1
Summary of Challenges to Evaluation

Issues	Challenges	Possible Strategies
Program variability	Differences in structure, components, and activities among MCPPs; varying amount of integration with other services; obtaining cooperation from services receiving or providing referrals	Carefully specify structural differences for the analysis; negotiate early with external agencies about their cooperation in the evaluation; establish confidentiality agreements among other service agencies and MCPPs
Appropriateness of referrals	Defining and rating appropriateness; different perspectives on obtaining medical diagnosis or treatment history; lack of information on diagnosis and severity of symptoms	Use standardized behavioural tools to measure client's functioning as opposed to diagnosis; use a subsample of clients referred or previously treated in hospital where diagnosis and treatment history is reliably established
Diverse perspectives	Philosophical differences between and among MCPPs, community and hospital-based services in identifying evaluation goals, variables, etc.	Use formal procedures for defining program's goals and objectives, including consensus-building strategies
Measuring "group" impact	Lack of homogeneity among patients within the same diagnostic group	Use goal-attainment scaling and benchmark the outcome measure for each client
Involvement of service recipients (consumers)	Compromised mental status of some recipients; lack of significant other for proxy; transient history	Use past service recipients; involve significant others when possible

For integrated programs and stand-alone programs (albeit to a lesser degree), it is difficult to determine where the MCPP services end and other services begin. That is, the core services of MCPPs may become confused with the delegated services. Moreover, in integrated programs the same staff are often used for the MCPPs and for case management. Commonly, the files are shared because each deals with the same target population, and the clients flow between the services. In these cases, follow-up visits from mobile crisis may include some case management.

One option would be to evaluate all the integrated services together and not attempt to tease out the unique contributions to outcomes resulting from the MCPPs. For a single program, that may be a feasible option as long as the goal is not to determine the unique effect of MCPP. For multi-site studies, however, evaluating the MCPPs with all the integrated services is too unwieldy. Multi-site evaluations of MCPPs are difficult because of how these programs are defined and designed — the programs may be quite diverse in the extent of their service integration.

One way to deal with the diversity of MCPPs is to conceptualize common dimensions across them and use this information to inform the evaluation inclusion criteria. However, although dimensions may appear similar, varying arrangements for service delivery may reduce their commonality. We discussed this earlier in terms of the structure of integrated MCPPs and stand-alone MCPPs, where the latter could have different partnerships to facilitate referrals. For example, a common dimension for multi-site evaluation may involve backup in-patient psychiatric care; however, some hospitals may be partners in the initiative whereas others are merely identified as being in the catchment area. The varying arrangements may manifest themselves as differences in how cases are triaged, in waiting times to be seen in the hospital, or in how cases are identified, none of which are apparent when specifying common dimensions.

Given these complexities, it will be important to specify important structural differences among programs and to measure these structural characteristics so that they can be considered in the analysis. If there are many differences to control for, the meaning of any evaluation will be limited, so identifying important structural differences will be the key. As one may not know all the important variables, it is possible that a specification error is committed where relevant variables are omitted from the analysis. Measuring the important

structural characteristics may not make it possible to fully tease out the components of a program that lead to its success or failure, but specifying the inclusion criteria and measuring important structural differences will help in determining possible characteristics predictive of a MCPP's success or failure.

If one evaluates the MCPP as a community outreach program in isolation from assessment or treatment services, there needs to be a focus on the referral function (e.g., service coordination and appropriateness of the referral). The evaluator must consider how best to conceptualize this function, find objective and measurable variables to represent the activity, and obtain the cooperation of other agencies so that relevant data can be collected. Negotiating with "external" agencies about an evaluation study is difficult, as participation may be perceived as threatening; the results could affect them because receiving referrals and coordinating services are shared activities. Obtaining access to the records or information from another agency involves issues of confidentiality and informed consent. If the MCPP to be evaluated is integrated with other services, then participation and cooperation from these integrated services may be less of an issue because of a shared structure, although this remains to be seen.

Early identification of the need to involve other agencies and their data about an MCPP will help in determining whether there will be limits to the present evaluation and deciding on a method for collecting the confidential data. Developing and using confidentiality agreements will help in establishing the limits of sharing the information and will assist in building trust among organizations. An understanding of health legislation concerning access to personal health information is essential for developing the confidentiality agreements and for understanding the limits of sharing data for the purposes of research or evaluation.

Evaluating appropriateness of referrals

Outcome measures for MCPPs should address the appropriateness of a referral and the relationship of the MCPPs to the programs to which they refer. If there were clinical benefits, they would likely be the result of service providers to whom the consumer is referred and not the MCPPs. However, it is important to examine clinical outcomes as long as the purpose of doing so is to help conceptualize the appropriateness of referrals. MCPPs increase access to care, and

hence their impact may be to increase rather than decrease utilization of some services in a historically underserviced group — including hospital admission. If the appropriateness of referrals is not measured, the evaluator cannot conclude with validity whether a desired decrease in unnecessary hospitalizations and increase in appropriate hospitalizations has been achieved.

The need to evaluate appropriateness leads evaluators into difficult areas: rating it, assigning values to change, and considering nonmonetary benefits involved in doing nothing versus increasing service utilization. Economic evaluations of integrated programs with multiple stakeholders are always difficult, and when one adds the need to weigh social costs in an intricate cost-benefit model, the task becomes even more complex.

To rate the appropriateness of referrals, evaluators need to determine if clients were correctly assessed and if they were appropriately sent to either hospitals or community services based on an accurate assessment. To do this, the clinical information about the client, including diagnosis and severity of symptoms, must be available and considered. Given that all the recipients will originate from the community and only those at high risk will receive hospital-based care, the characteristics to be measured to determine the appropriateness of the referral must have validity for a community psychiatric population and be acceptable to those holding a community-based perspective. Variables such as mental health status, primary diagnosis, and treatment history may not be universally accepted concepts among community-based services. Even if they were, they may not be available for all those served (e.g., non-high-risk for hospital-based care).

One option may be to focus on behavioural assessment based on direct observation at the time of the MCPP visit rather than on the client's medical diagnosis or treatment history. Observational aids such as checklists and rating scales could be employed in the field. A good behavioural assessment tool will provide a uniform, objective score scale that relies less on the clinical judgement that is required in the diagnostic role. The reliability of assessment techniques across observers and across situations would need to be considered. We are not aware of any behavioural tool in general use in mobile crisis programs. However, the Crisis Triage Rating Scale (CTRS) shows great promise in determining whether clients require hospitalization based on crisis assessment rather than on diagnosis (Bengelsdorf, Levy, Emerson, & Barile, 1984). The CTRS, developed

for use by mobile crisis intervention services, has three dimensions: (1) dangerousness to self and others; (2) support systems; and (3) motivation and ability to cooperate. Five descriptive statements are given as examples for each of the possible scores in each area. Crisis workers trained in using the scale assign a grade of 1 to 5 for each of the three categories. Summing the three scores provides the crisis triage rating. The lower the score, the higher the likelihood that hospitalization is necessary. Early trials show that individuals who scored less than 8 were referred for admission to hospital, and those who scored 10 or higher tended to be treated in the community (Bengelsdorf et al., 1984). (We have revised this tool to include drug and alcohol, and the revised version is in use in at least one Ontario crisis program.) Further study with respect to the psychometric properties of the tool is warranted.

Another option, if an evaluator wants to use a medical diagnosis or treatment history, may be to focus the evaluation on those clients who are referred to hospital and assess the appropriateness of these referrals. This method could provide a clearer diagnostic history. However, what one would not know is whether someone referred from the MCPP to community services would more appropriately have been referred to hospital. The original referral would be to a known hospital; however, subsequent hospital care could be sought outside the geographic boundary of the program, making patients difficult to track. If an evaluator has access to administrative data that will allow for tracking (e.g., third-party reimbursement databases), it may be possible to capture all hospital visits or inpatient care days during the study period. However, as MCPPs would have no reason to ask patients routinely to provide information that will allow for this tracking (e.g., health care number), and as some program providers may believe this tactic is in conflict with their community-based philosophy, this option may not be feasible. Obviously, if health care identification numbers were provided, it would also be easier to identify cases referred to the hospital and the outcome of the assessment/treatment without necessarily conducting chart abstractions. Nevertheless, focusing on clients taken to hospital to determine appropriateness of the referral may be helpful, despite some limitations.

Diverse Perspectives

MCPPs, like other services with multiple stakeholders and professional disciplines, need to deal with diverse perspectives. This is a

common problem in all evaluation studies, especially in integrated programs (Knapp, 1996), and it concerns which variables are identified for study and the priority given to each (e.g., the objectives, program components, activities, etc.), among other things.

There are two ways that diverse perspectives pose a problem for MCPPs. First, there may be philosophical differences between community and hospital-based services, and the two may have different relationships with MCPPs. Second, even within the same sector (e.g., community) there may be differences in perspective about the focus of the evaluation. In part, these differences may reflect the nature and level of integration of MCPPs with other services.

The challenge is to determine which dependent variables will be considered in the conceptualization, design, and interpretation of the evaluation study. Sometimes variables can be eliminated because they are not objectifiable and measurable, but often evaluators are left with a host of variables that could potentially be included. One needs to ensure that the study variables are inclusive enough to ensure a valid study, yet limited enough that the research is manageable. Unfortunately, evaluators are often left without a clearly articulated program logic model and without resolution of these issues. Even if the model is completed at the time of planning, evaluators often find that not all of the short- and long-term outcomes can be included in an evaluation study, or that many are in dispute. Hence, the task of prioritizing them falls to the evaluator, who must consult with the program decision-makers and stakeholders to determine which variables will be included in the research.

Information about diverse perspectives should be considered at the time of program planning when there are discussions about the goals, objectives, and activities, and how the activities and dependent variables will be logically or theoretically linked to the program. A strong conceptual framework can make explicit the assumptions of the program (Knapp, 1996). Program logic models are a common way to depict this relationship, and hopefully many issues can be resolved during this process. However, disagreements about the criteria for success are a major challenge to these programs because of the diverse perspectives among and between service recipients, service providers, and stakeholders. Using formal procedures for defining the program's goals and objectives may help address this diversity. There are a number of formal mechanisms available for this purpose, including consensus methods (Brook et al., 1986; Fink et al., 1984). Articulating a program's theory in terms of its cause-and-

effect sequence, how the program intends to create desired interactions, and how it will provide these services may be helpful (Birckmayer & Weiss, 2000; Rossi, Freeman, & Lipsey, 1999).

Measuring the "Group" Impact

Although all efforts should be made to ensure that the target population is clearly defined, service recipients may still not be homogeneous given the diversity of major mental disorders. Trying to establish a uniform or group benchmark against which to compare outcomes may be difficult. For example, the benchmark may be whether a service recipient is able to remain in the community for six months without in-hospital care. For some recipients, being hospitalized no more than twice during the six months may be a more feasible goal. However, if the outcome was set at two hospitalizations for all recipients, the program's impact might be artificially high, as the outcome measure was selected for the lowest common denominator. Also, reducing hospitalizations may not be sufficient evidence to show the program's worth; being able to avoid unnecessary hospitalization entirely may be a better indicator of success.

One strategy may be to measure the impact using individually tailored rather than group outcomes. First introduced by Kiresuk and Sherman (1968), goal-attainment scaling (GAS) has been incorporated as an evaluation tool because of its unique focus on the needs, abilities, and aspirations of those receiving a service. GAS establishes standards of achievement and expresses them in terms of proportionate improvement rather than the total elimination of undesirable conditions/states or the absolute adoption of a desirable one. This method allows evaluators to use specific outcomes; however, the benchmarks for success in interpreting the outcome measure are specific for each service recipient, and the results for the entire group are used to estimate the program impact. Because the rating process and formula are standardized, it is possible to compare within and across groups (Kiresuk & Lund, 1979). GAS has recently been used with a clinical population with success (Stolee, Zaza, Pedlar, & Myers, 1999). There are, however, some limitations to the method, including concern about how well mental health workers can accurately predict prognosis at follow-up (see Kiresuk & Lund, 1979, for an in-depth discussion of the strengths and limitations of GAS). Despite its limitations, GAS remains attractive for some evaluations (Rossi & Freeman, 1993).

Involvement of Service Recipients (Consumers) in an Evaluation

Essential to an evaluation of any health program are the service recipients themselves. Because of compromised mental status, some recipients may be unable to identify services that they received, when, or by whom. Furthermore, many service recipients are without family or live on their own, making it difficult for evaluators to corroborate information. Some recipients may receive care only once or infrequently, and may not remember receiving it or know when it was delivered. Obviously, the crisis itself may make it difficult to recall details or to even discern that a specific service was different from others that had been received. Also, just as the evaluators may have difficulty determining MCPPs' core functions, clients of the program face similar confusion.

MCPPs, like other programs that deliver services to clients with significant mental disorders, have to recognize that these individuals in the throes of a crisis may not be able to provide — nor, ethically, should they be asked to provide — information for research purposes. Thus, contact after the time of delivery of the crisis service is needed to obtain informed consent. Unfortunately, because the population may be transient, arranging for repeat calls or visits for program evaluation may be difficult. The problem of obtaining data from a transient mentally ill population is compounded when one tries to examine outcomes longitudinally.

From an evaluative perspective, one must find ways to capture the opinions of service recipients, as only they can provide input about the acceptability of the MCPPs to the target audience. One must ensure that the outcome: (1) is valued by the recipient and by service providers; (2) is objective and measurable; (3) is logically connected to the program; and (4) can be evaluated longitudinally. Not uncommonly, the outcomes valued by mental health service recipients and by service providers are not the same. For example, a recipient may value remaining in the community above all else, whereas the providers will not view this outcome as a success if there remains a serious risk of harm to self or others. Some recipients and providers disagree about whether individuals who suffer from self-neglect should remain in the community or be seen in hospital. It is precisely because of this difference in viewpoints that we must find ways to include service recipients' opinions and experiences in evaluating MCPPs.

Using past service recipients may be one method to elicit opinions from the target population. One could also involve significant others (e.g., spouse, children, parent, partner, friend, advocate) in the planning of the evaluation, especially regarding their opinion about appropriate outcome measures. Many scholars have argued for an "emancipatory framework" in evaluation that gives voice to the perspectives of marginalized groups and addresses issues such as social justice (see, e.g., Mertens, 1998; Mertens, Farley, Madison, & Singleton, 1994).

DISCUSSION

There are three main issues to address with respect to evaluating MCPPs. First is the coherence of the program models and the way that programs vary in the underlying models, including the degrees to which the models correspond to the realities of clients' needs. This relates to the extent to which MCPPs are integrated with other related psychiatric, health, and social services. Second, evaluators need to resolve specific measurement problems, such as evaluating the appropriateness of referrals, diverse perspectives, and measuring a group's impact when clients are not a homogeneous population. Third is the logistics of studying persons who are in crisis.

The inclination may be to support evaluation studies that focus on improving these programs rather than on determining their effectiveness. Improving a service to ensure quality of care is important, but one still also needs to determine if the service is an appropriate and cost-effective option in the first place.

Evaluation is useful only if it is credible with generalizable results. Can comprehensive evaluations that include effectiveness or impact be useful or valid with respect to MCPPs? We believe that they can be, but only if the methodological issues concerning these programs are considered. Rather than pursue the elusive ideal that only serves to frustrate health service evaluators and their funding agencies, a more realistic evaluation should approach this important service component in a fresh manner. This can be accomplished, at least in part, by addressing the problems inherent in these programs and being prepared to deal with their impact and pervasiveness.

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