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WHICH COMMUNITY MENTAL HEALTH SERVICES ARE MOST IMPORTANT?

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ABSTRACT: This study interviewed 364 members of four local countywide stakeholder groups (service provider agency directors, case managers, clients, and family members of clients) in a northwest state to ascertain their extent of agreement or disagreement about the importance of services. The groups agree that basic assistance and living skills are most important and that helping clients set their own goals and obtaining support from community organizations are least important. A social system stakeholder model proposes that the agreement and disagreement of different stakeholder groups are related to their values and position in the service delivery system.

The Community Support Program (CSP) of the National Institute of Mental Health (NIMH) is one of the most influential models of community-based services for the seriously mentally ill. The CSP concept holds that persons with long-term mental disabilities need a wide range of community services (called a community support system). Accordingly, each community should provide all of the 10 "essential services" needed by the chronically mentally ill adult: outreach; assistance in meeting basic needs; mental health care; crisis assistance; psychological services; housing; assistance/consultation and education; natural support systems; protection of client's legal rights; and case management (Turner & Ten Hoor, 1978; Tessler & Goldman, 1982; Stroul, 1986).

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This paper addresses two issues. The first is the question of the extent to which the 10 essential services or some part of this set are viewed as important by key stakeholder groups in countywide CSP delivery systems. It is one thing for a high-level federal organization such as the NIMH to claim that a particular set of services is important and quite another for local stakeholder groups to agree. Hence, the first issue involves the extent to which local stakeholder groups, including the seriously mentally ill themselves, affirm that these 10 services are essential.

A second issue concerns the relative importance of the 10 services. Implicit in the CSP model is the idea that all 10 services are equally important for the seriously mentally disabled client. We wish to discern empirically whether this is the case, or alternatively, if some community-based services are more important than others and if so, which ones. Such information is especially important in an era of fiscal restraint where cutbacks in services are an ever present possibility. Finally, if differences are found, we wish to know why stakeholders differ in their evaluation of services.

A Social Structural Approach to Program Priorities. Our study draws on the idea that evaluations of services and organizations are related to positions in the social structure. Each of the essential mental health services described above consists

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of an attempt to put into practice some social or therapeutic value. Communities are highly differentiated social systems, consisting of groups with different levels of resources, modes of organization, and vested interests in community programs and policies. Since social position and group membership affect orientation toward values, one would anticipate that group membership and position in community structure would also influence views on the importance of these different services.

Members of groups that are vitally affected by decisions involving particular programs, or that make those decisions, are commonly termed stakeholders (Weiss, 1983(a)). Examples of groups that hold a stake in public welfare and mental health programs include policy makers, adminstrators, practitioners, and clients. Members of stakeholder groups bring multiple perspectives to bear on judgments about programs. Evaluation researchers are now recognizing that, although such groups have divergent, even incompatible program interests, all stakeholders' interests are equally legitimate and their evaluative judgments should be considered equally valid. Using a stakeholder approach acknowledges the inherently political nature of the evaluative process (Weiss, 1983(a); 1983(b)).

Approaching the evaluation issue from a different angle, Connolly, Conlon, and Deutsch (1980) arrive at similar conclusions. Their work, from the organizational effectiveness literature, illustrates the value of adopting a "multiple-constituency" approach to effectiveness, in which the assessments of constituents with different positions in the organization, such as directors, middle managers and workers, are taken into account in evaluating effectiveness. These authors label as arbitrary the traditional assumption that it is feasible and desirable to establish a single set of evaluative criteria for organizations, since evaluations are likely to vary by position in the organization. Instead, they believe the question of whether a single perspective succeeds in dictating which evaluative criteria will be used is answerable only through empirical discovery and cannot be assumed *a priori.*

The services chosen as most important are help with obtaining basic assistance.

The most significant stakeholder groups in mental health service systems for seriously mentally ill persons are (1) service-providing and administrative organizations; (2) service providers working directly with clients, who in the case of CSP programs are typically case managers; (3) clients; and (4) the family members of clients. These four groups can be further subdivided into service providers—that is, the administrators and directors of agencies and the case managers—and consumers, including clients and families.[1]

Following the stakeholder approach outlined above, we consider it unwarranted to assume *a priori* that these different groups will share a unified perspective on service priorities, the issues and information that are crucial for decision-making, or treatment goals and expectations. Instead, at least in some cases, we expect to find differences among stakeholders that reflect their distinctive interests and roles within the mental health system. At times, the assessments of service importance by members of the four groups may provide evidence of a shared perspective, particularly when their treatment agendas do not conflict. In other words, we expect that some services will be seen as important by all four groups.

However, consistent with the multiple stakeholder approach, the literature also suggests that position in the mental health system affects perceptions of program priorities (Ahr & Holcomb 1985; Miller, 1981; Grob, Eisen, & Berman, 1978). Thus, we also expect differences in stakeholders' evaluations of services. Although there is little systematic information on precisely how stakeholders' views will differ, we do expect a basic distinction between provider and consumer service priorities, based on their very different positions in the service system. In addition, existing evidence, although limited, suggests that within the consumer group, clients and family members should differ in their service priorities, with the former assigning more importance to services

aiming at improved living situations, social circumstances, and legal rights, and the latter expressing more concern with services that would reduce their caregiving burdens (Hatfield, 1979).

METHODS

Data were collected from 364 members of four stakeholder groups (directors of major service providing agencies, case managers, clients, and family members of clients) as part of a study of CSP effectiveness in eight counties in a northwest state. The state studied ranked 30th in the United States in population. A comparison with other mental health systems suggests that its fiscal year 1981 mental health expenditures were typical. It ranked 36th in per capita expenditures on state mental hospitals, 21st in per capita expenditures on community programs, 20th in total federal revenues for mental health programs, and 27th in total state mental health division expenditures.

Approximately equal numbers of each stakeholder group were interviewed in each county. The organization director sample (N = 156) is composed of heads of the 19 or 20 most important organizations in each county that provide services to seriously mentally ill persons (Grusky, 1988; Grusky & Tierney, 1989).

The case manager group (N = 49) consists of staff members in county mental health agencies (typically, but not necessarily, the designated lead mental health agency) who perform case management activities (providing information and referral, monitoring client progress, helping clients obtain needed services) for seriously mentally ill clients. Unlike most organizational directors, case managers spend much of their time in direct contact with clients. In the majority of counties, all case managers were interviewed; in counties with larger staffs, only a segment of the case management staff was interviewed.

The clients interviewed (N = 82) were contacted with the assistance of case managers. The criteria for client selection were: (1) experience with the local system of care for seriously mentally ill persons, and (2) the ability to communicate in an interview situation. About 10 clients were interviewed in each of the eight sites. Clients were 95% caucasian and 59% male, with a median age of 38. They had a median annual income of $2,846. They averaged 4.6 prior hospitalizations; 95% were on medication and most were diagnosed as schizophrenic.

Family members (N = 77) were also contacted with the assistance of case managers. Again, the emphasis was on identifying family members who were knowledgeable about the system of care in the county and could therefore make judgments about the quality and importance of different community-based services.

Questions about the importance of service components were asked in face-

to-face, tape-recorded interviews that sought to obtain stakeholders' perceptions of various dimensions of service system performance. For greater clarity and specificity, the 10 service components identified by NIMH were further broken down into 13 elements. Following a series of questions to elicit stakeholder views on the availability and quality of each service component, interviewees were asked to identify the five most important services.[2]

RESULTS

The first finding is that not all services are perceived by stakeholders as equally important. Overall, the services chosen as most important are help with obtaining basic assistance, such as food and income entitlements, training in basic living skills, mental health care, client outreach, and crisis assistance (Table 1). Second, the data indicate that while there is agreement among the four groups on the importance of some services, there are also significant areas of disagreement; that is, stakeholder affiliation makes a difference in service evaluation.

Areas of Agreement and Disagreement. The four groups agree on the importance of providing help with basic assistance, 24-hour crisis assistance, and mental health care. All four groups rate services aimed at helping seriously mentally ill persons get basic assistance as highly important (Table 1). Crisis assistance and mental health care are also ranked high in importance by all stakeholder groups. Not anticipated is the very high importance assigned to providing training in basic living skills.

Table 1 also indicates that some services are considered relatively unimportant. All interviewees rank services to persuade community organizations to get involved in helping seriously mentally ill persons as low in importance. Services to help clients set own goals and to provide support to families are also not a high priority among the four stakeholder groups.

Table 2 reports the results of analyses of variance testing for intergroup differences in the perceived importance of each of the thirteen key services.[3] There are no significant differences with respect to six services: basic assistance, crisis assistance, services to help clients with goal-setting, housing, support to families, and case management. Some of the six are rated as highly important while others are not; but members of the four stakeholder groups are more or less in agreement on the priorities they assign to these services. There are, however, significant differences in the importance the four groups assign to seven of the services. Differences are particularly marked regarding services to identify clients, mental health care, social skills training, and job assistance.

Intergroup Differences. Table 3 presents the results of logistic regressions for nine different stakeholder group comparisons on each of the key services. It

Table 1
Rankings of Key Services by Stakeholder Groups

	Stakeholder Group									
	(N = 156) Org. Directors		*(N = 49) Case Managers*		*(N = 77) Families*		*(N = 80)[a] Clients*		*(N = 362) All*	
Service	*Rank*	*N*	*Rank*	*N*	*Rank*	*N*	*Rank*	*N*	*Rank*	*N*
Outreach to Client	3.5	(91)	9	(15)	4	(37)	8.5	(29)	4	(172)
Basic Assistance	1	(106)	1	(33)	1	(49)	1	(54)	1	(242)
Mental Health Care	3.5	(91)	7	(19)	8	(30)	5.5	(33)	3	(173)
Crisis Assistance	5	(78)	4	(26)	6	(31)	3	(36)	5	(171)
Help Set Own Goals	11.5	(29)	10	(9)	12.5	(14)	12	(15)	12	(67)
Basic Living Skills	2	(102)	2	(32)	3	(39)	2	(40)	2	(213)
Social Skills	9	(36)	5	(25)	9	(29)	10	(28)	9	(118)
Job Assistance	8	(38)	11.5	(8)	2	(41)	4	(35)	8	(122)
Housing	7	(64)	3	(29)	6	(31)	8.5	(29)	7	(153)
Support for Families	11.5	(29)	8	(16)	11	(19)	11	(25)	11	(89)
Community Orgs. Support	13	(13)	13	(2)	12.5	(14)	13	(12)	13	(41)
Legal Rights of Mentally Ill	10	(30)	11.5	(28)	10	(20)	5.5	(33)	10	(91)
Case Management	6	(73)	6	(23)	6	(31)	7	(31)	6	(158)

[a]Two clients declined to answer this question. The original N was 82.

was found that service providers (organization directors and case managers) tend to view mental health-related services (identify clients, mental health care, crisis assistance, goal-setting, and case management) as more important than do consumers (clients and family members). Column g in Table 3 shows that there are provider-consumer differences in judgments about mental health care, but the two groups agree about the importance of crisis assistance and case management.

Two other differences between service providers and service consumers were observed. First, service providers are less likely than consumers to see job assistance as an important service for seriously mentally ill clients. We found a true provider-consumer split with respect to this service element; that is, while there are no significant differences between the importance ratings of organization directors and case managers or families and clients, significant differences are demonstrated between provider and consumer groups. Both organization directors and case managers perceive job assistance as less important than do families and clients.

Providers are less likely than consumers to see job assistance as important for the seriously mentally ill client.

Second, consumers are significantly more likely than providers to value services that mobilize community organizations to do more for seriously mentally ill persons. Interestingly, the data comparing organization directors and case managers indicate a split in the service provider camp: organization directors view mental health-related service elements (identify clients and mental health care) as more important than do case managers, who in turn, see practical issues (social skills training and housing assistance) as more important than do organization directors.

It could be argued that clients would be more likely than the members of other stakeholder groups to be concerned about services that help them cope better with problems in living: help with obtaining basic assistance, training in basic living skills and social skills, housing and job assistance, and client legal rights. However, as Table 3 indicates, the evidence is mixed. Clients are more likely than other stakeholders to see job assistance as an important service, and they are much more likely to believe that there is a need for services to safeguard their legal rights (column h). Comparisons of clients with each of the other groups (columns e and f) indicate that clients regard the protection of their legal rights as significantly more important than do any other group.

Clients do not differ from the other three stakeholder groups as a whole in the importance they attach to help with basic assistance, social skills training, and housing. The difference between the two categories of stakeholders with respect to living skills training is significant at $p < .10$, but interestingly, other stakeholder groups are slightly more likely than clients to see this service as

Table 2
Stakeholder Judgments of Importance of Services

Service	*Stakeholder Group*	*Mean*	*Prob.*
Outreach to Client	Org. Dirs.	.583	.000
	Families	.480	
	Clients	.362	
	Case Managers	.306	
Basic Assistance	Org. Dirs.	.679	N.S.
	Families	.675	
	Clients	.673	
	Case Managers	.636	
Mental Health Care	Org. Dirs.	.583	.006
	Families	.412	
	Clients	.389	
	Case Managers	.387	
Crisis Assistance	Org. Dirs.	.531	N.S.
	Families	.500	
	Clients	.450	
	Case Managers	.403	
Help Set Own Goals	Org. Dirs.	.187	N.S.
	Families	.186	
	Clients	.184	
	Case Managers	.182	
Basic Living Skills	Org. Dirs.	.654	.040
	Families	.653	
	Clients	.506	
	Case Managers	.500	
Social Skills	Org. Dirs.	.510	.001
	Families	.377	
	Clients	.350	
	Case Managers	.231	
Job Assistance	Org. Dirs.	.532	.000
	Families	.437	
	Clients	.250	
	Case Managers	.163	
Housing	Org. Dirs.	.592	.063
	Families	.404	
	Clients	.403	
	Case Managers	.362	

Service	*Stakeholder Group*	*Mean*	*Prob.*
Support for Families	Org. Dirs.	.326	.084
	Families	.312	
	Clients	.247	
	Case Managers	.186	
Community Orgs. Support	Org. Dirs.	.182	.034
	Families	.150	
	Clients	.083	
	Case Managers	.041	
Legal Rights of Mentally Ill	Org. Dirs.	.412	.001
	Families	.260	
	Clients	.192	
	Case Managers	.163	
Case Management	Org. Dirs.	.469	N.S.
	Families	.467	
	Clients	.403	
	Case Managers	.387	

important. The only other service about which clients differ from the other three groups is basic living skills. Clients surprisingly see this as less important than do other stakeholders.

Clients assign more importance to their legal rights than families do.

Because families can find their resources greatly taxed by the responsibility for caring for a seriously mentally ill relative, we expected that families would view as most important those service components that are likely to reduce family burden, namely 24-hour crisis assistance, housing, job assistance, and support to families. However, it was found that families are likely to see as important, relative to all other stakeholders, job assistance and community organization support (column i). They are less likely to stress mental health care and basic living skills. Overall, the findings indicate that families' ratings differ significantly from service providers, but not from those of clients (columns c and f).

In general, the views of family members on service importance tend to resemble the views of the other three groups, taken as a whole. The only differences that approach significance are in the importance assigned to mental health care, which families see as less important, and work with local organizations, which families see as more important than do the other three groups.

As a final step in the analysis, differences within the provider and consumer

Table 3
Logistic Regression Analyses of Stakeholder Group Differences[a]

Service	*(a) Org. Directors vs. Case Managers*	*(b) Org. Directors vs. Clients*	*(c) Org. Directors vs. Families*
Outreach to Clients	.577****	.451***	.207
Basic Assistance	.014	.010	.096
Mental Health Care	.397**	.345**	.393***
Crisis Assistance	−.061	.100	.197
Help Set Own Goals	.007	−.005	.014
Basic Living Skills	.002	.318**	.305**
Social Skills	−.622****	−.292*	−.350**
Job Assistance	.268	−.424***	−.614****
Housing	−.381**	.088	.003
Support for Families	−.376**	−.344**	−.180
Comm. Orgs. Support	.380	−.332	−.447**
Legal Rights of Mentally Ill	.100	−.541****	−.194*
Case Management	−.003	.165*	.133

KEY: **** < .001
*** < .01
** < .05
* < .10

[a]All coefficients are logistic regression coefficients. Hence the odds of $(p_1/1-p_1)$ / $(p_0/1-p_0)$ is exp. (coefficient × 2). For example, the odds of org. directors choosing OUTREACH TO CLIENTS as one of the most influential services are 2.96 times as great as that of case managers.

groups are considered. The importance ratings of organization directors and case managers differ significantly in four service elements: organization directors consider the identification of clients (outreach) and mental health care to be more important than do case managers, and case managers rate social skills training, housing, and support for families as more important than do organization directors (column a). This split in the provider camp can be explained by reference to distinctive roles in the caregiving system. Since case managers work in direct contact with clients on a continuing basis, they perceive service elements having a pragmatic basis as important. At the same time, their relative underemphasis on client outreach makes sense in light of their frequently heavy caseloads and problems with burnout.

A comparison of families and clients presents a more unified picture. Service recipients differ significantly with respect to only two service elements, where clients assign more importance to their legal rights than families do, and families assign more importance to job training than clients do (column f). Again, their responses can be comprehended by considering their respective

Table 3
Stakeholder Group Differences (Continued)

Service	*(d) Case Managers vs. Families*	*(e) Case Managers vs. Clients*	*(f) Clients vs. Families*
Outreach to Clients	−.370	−.127	.243
Basic Assistance	.082	−.003	−.086
Mental Health Care	−.004	−.052	−.048
Crisis Assistance	.259	.162	−.100
Help Set Own Goals	.006	−.013	−.019
Basic Living Skills	.303*	.316*	.013
Social Skills	.272	.330*	.058
Job Assistance	−.882****	−.691***	.191*
Housing	.383**	.468**	.085
Support for Families	.196	.032	−.164
Comm. Orgs. Support	−.826**	−.711*	.115
Legal Rights of Mentally Ill	−.293	−.640***	−.347**
Case Management	.136	.168	.032

KEY: **** < .001
*** < .01
** < .05
* < .10

agendas. As a disenfranchised group, clients desire control over some aspects of their lives and see protection of their legal rights as a crucially important element of that process. As caregivers and parties interested in the welfare of their relatives, family members perceive the exercise of those legal rights as detrimental to the provision of proper care to clients.

When comparing the importance of organization directors with those of the two consumer groups, a number of distinctions (columns b and c) are found. Significant differences exist between organization directors and families regarding six service elements, and between organization directors and clients on seven such elements. Case managers' importance ratings are significantly different from families on four services and from clients on six services. Together, these findings suggest that (1) the consumer-stakeholder groups—families and clients—have highly overlapping perspectives on service importance; (2) the provider-stakeholder groups hold relatively less unified perspectives on service importance; and, related to the second point, (3) case managers occupy a position midway between organization directors and consumers regarding agreement on service elements.

These findings reflect the fact that evaluations of community-based services

Table 3
Stakeholder Group Differences (Continued)

Service	*(g) Providers[b] vs. Consumers*	*(h) Others vs. Clients*	*(i) Others vs. Families*
Outreach to Clients	.195	.296**	−.014
Basic Assistance	.050	−.019	.091
Mental Health Care	.273**	.170	.228*
Crisis Assistance	.162	.058	.180
Help Set Own Goals	.002	−.010	.014
Basic Living Skills	.311***	.231*	.212*
Social Skills	−.148	−.069	−.143
Job Assistance	−.574****	−.270**	−.518****
Housing	.137	.154	.045
Support for Families	−.163	−.219	−.003
Comm. Orgs. Support	−.461***	−.216	−.377**
Legal Rights of Mentally Ill	−.403***	−.499****	−.028
Case Management	.150	.129	.088

KEY: **** < .001
*** < .01
** < .05
* < .10
[b]Providers = Org. Directors + Case Managers
Consumers = Clients + Family Members

for seriously mentally ill persons are not consistent throughout the caregiving system. Instead, there are similarities and differences in the assessments of multiple constituents which are systematically related to their work and their social positions in the community.[4]

CONCLUSIONS

The findings demonstrate that there are several services about which community participants agree. At the same time, groups that have different roles in the community service system also have different views on the importance of service elements.

Recognition that stakeholder groups may differ in the importance they assign to service elements can lead to a better understanding of the roots of dissatisfaction with services and conflicts among groups whose positions in the system are dissimilar. For example, it has been shown that seriously mentally ill clients and their families have service priorities that are often at variance

with those of high-level system representatives. The high priority assigned to job training by clients and families and the lack of corresponding emphasis by providers is a case in point. To the extent that jobs or other services valued by consumers are deemphasized by service providers, consumers may become dissatisfied with the entire caregiving system. Conversely, when service providers attempt to stimulate interest in services that are not viewed as important by consumers, services may be underutilized, and providers may become frustrated and discouraged.

Official CSP policy identifies ten specific components as essential for the provision of community-based services to seriously mentally ill persons. However, this paper presents evidence that participants in community service systems do not see all key services as equally important. These findings suggest that it is possible to further prioritize services, even among services that are considered by powerful groups to be essential. CSP presents an "ideal type" comprehensive system. However, where resources to provide all services are insufficient (as is almost always the case) or where the need for particular services is great, the method presented here suggests a way to reconcile this ideal with local realities.

The foregoing analyses and the growing literature in the area demonstrate the utility of using a multiple consituency or stakeholder approach to the determination of service priorities, as well as in other aspects of service evaluation. Key informant surveys such as those planned as part of the Robert Wood Johnson Foundation (RWJ) intervention evaluation (Morrissey, Ridgely, & Goldman, 1988) to assess the impact of the RWJ/Housing and Urban Development intervention on services may encounter systematic bias if assessments by clients and families are not included. Eliciting judgments of service importance from individuals who share a common structural position in the service system, such as planners, administrators, or practitioners provides information on only one perspective; it cannot be assumed that these priorities are shared throughout the system. To obtain a balanced perspective, it is necessary to take into account the views of all relevant constituencies.

REFERENCE NOTES

1. Strictly speaking, the term "consumer" is inaccurate for family members, since families are also unofficial, and frequently, service providers of last resort.
2. The exact item was as follows: "Now I'd like you to review all thirteen cards that I have asked you about (each card describes a service or activity). Please indicate which *five* services are the most important."
3. As a reviewer pointed out the samples of the four stakeholder groups were not drawn randomly. The significance levels reported should be interpreted with caution since cluster sampling was used (Sudman, 1976).
4. A reviewer observed correctly that the eight counties may differ in resource availability and that this could influence respondent perceptions of services. We attempted to measure resources by examining the budgets of the top 19 or 20 organizations that compose the service provider network in each county. We also developed some other resource measures (Grusky, 1988). The difficulty was in obtaining information

on the actual number of chronically mentally ill clients in each county so that the resource measures could be standardized to take into consideration service demand. Torrey and Wolfe (1986) conducted a study of state mental health programs that included data on all fifty states and the District of Columbia. They found little correlation between their measures of state program quality and mental health expenditures. They considered this their most surprising finding. They found, for example, that the District of Columbia's (ranked 43rd in program quality) per capita expenditures exceeded the per capita expenditures of six of the seven state programs rated the highest in quality, and noted; "If spending money alone would buy a good system, the District of Columbia would be the elite." It is reasonable to assume that a certain base level of resources is essential for service system effectiveness. However, once that level is attained it may be that additional resources do not uniformly improve system effectiveness.

REFERENCES

Ahr, P.R., & Holcomb, W.R. (1985). State mental health directors' priorities for mental health care. *Hospital and Community Psychiatry, 36,* 39-45.

Connolly, T., Conlon, E.J., & Deutsch, S.J. (1980). Organizational effectiveness: A multiple-constituency approach. *Academy of Management Review, 5,* 211-217.

Grob, M.C., Eisen, S.V., & Berman, J.S. (1978). Three years of follow-up monitoring: Perspective of formerly hospitalized patients and their families. *Comprehensive Psychiatry, 19,* 491-499.

Grusky, O., & Tierney, K. (1989). Evaluating the effectiveness of countywide mental health care systems. *Community Mental Health Journal, 25*(1), 3-20.

Grusky, O. (1988). Interorganizational structure and mental health service system effectiveness. Paper presented at the American Public Health Association Meeting, Boston.

Hatfield, A.B. (1979). The family as partner in the treatment of mental illness. *Hospital and Community Psychiatry, 30,* 338-340.

Miller, F.T. (1981). Mental health center versus community perceptions of mental health services. *Journal of Community Psychology, 9,* 204-209.

Morrissey, J.P., Ridgely, S., & Goldman, H.H. (1988). National evaluation of the Robert Wood Johnson Foundation Program for the Chronically Mentally Ill: Research plan for site-level evaluation. Unpublished manuscript, Center for Health Services Research, University of North Carolina, Chapel Hill, NC.

Scott, W.R., & Black, B.L. (1986). *The organization of mental health services: social and community systems.* Beverly Hills, CA: Sage.

Stroul, B.A. (1986). *Models of community support services: approaches to helping persons with long-term mental illness.* Boston, MA: Center for Psychiatric Rehabilitation, Boston University.

Sudman, S. (1976). *Applied sampling.* New York: Academic.

Tessler, R.C., & Goldman, H.H. (1982). *The chronically mentally ill: Assessing community support systems.* Cambridge, MA: Ballinger.

Torrey, E.F. & Wolfe, S.M. (1986). *Care of the seriously mentally ill: A rating of state programs.* Washington, DC: Public Citizen Health Research Group.

Turner, J.C., & Ten Hoor, W.J. (1978). The NIMH Community Support Program: Pilot approach to a needed social reform. *Schizophrenia Bulletin, 4,* 319-348.

Weiss, C.H. (1983). The stakeholder approach to evaluation: Origins and promise, in stakeholder-based education. In A.S. Bryk (Ed.) *New directions for program evaluation, no. 17.* San Francisco: Jossey-Bass.

Weiss, C.H. (1983). Toward the future of stakeholder approaches in evaluation, in stakeholder-based education. In A.S. Bryk (Ed.), *New directions for program evaluation, no. 17.* San Francisco: Jossey-Bass.