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CONSULTING TO IMPLEMENT NONTRADITIONAL COMMUNITY PROGRAMS FOR THE LONG-TERM MENTALLY DISABLED

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ABSTRACT: Research studies have documented the success of several models of community-based care for the long-term mentally disabled. Yet despite their success, these models have not been widely implemented. In the present case study, consultation, technical assistance and increased funding were provided to a community mental health agency to facilitate implementing an assertive community treatment program as an alternative to hospitalization. Numerous barriers to implementation were encountered, and an analysis of the community agency's response, based on principles from the planned change literature, is presented. Recommendations for future program change efforts on behalf of the long-term mentally disabled are included.

Over the last ten years, there has been increased attention to the deinstitutionalized mental patient and recognition of the fact that with adequate community support, persons with long-term mental illness need not and should not be expected to spend long periods of their lives in mental hospitals. For an even longer period of time, a significant body of literature has accumulated concerning nontraditional alternatives to the hospital and their effectiveness in reducing patient recidivism and/or number of days in the hospital. These interventions are diverse, encompassing models such as a residential lodge (Fairweather, 1964), intensive case management in an in vivo setting (Stein, Test and Marx, 1975), psychosocial rehabilitation in a clubhouse setting (Beard, 1976; Malamud, Beard and Croswell, 1974), and others. Kiesler (1982) has identified ten such interventions which fit his rigorous criteria of a true experimental research design contrasting hospitalization with an alternative treatment. In no case was hospitalization outcome more positive than the alternative and, in most, the alternative was more effective vis-a-vis costs and independent living.

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In 1978, the National Institute of Mental Health (NIMH) established a Community Support Program (CSP) initiative for states and local communities. Relying on the experiences and research from these nontraditional program models, NIMH/CSP subsequently described essential components of a community support system, i.e., the types of services and programs necessary to maintain persons with long-term, severe, disabling mental illness in the community (NIMH, 1982):

1. Assertive outreach
2. Meeting basic needs
3. Providing adequate mental health care
4. Providing 24 hour crisis response
5. Providing comprehensive psychosocial services
6. Providing a range of housing options
7. Offering backup support to community caregivers
8. Recognizing and using natural support system
9. Protecting client rights
10. Facilitating use of formal and informal helping system

However, despite this flurry of literature and the documented effectiveness of numerous community-based interventions, hospital recidivism rates remain high. Furthermore, traditional services are still the favored treatment modality offered through the majority of community mental health agencies, despite their proven ineffectiveness in reducing recidivism rates and despite the fact that many clients refuse these services or find them unacceptable, and therefore drop out (Stern and Minkoff, 1979; Talbot, 1979).

The Michigan Department of Mental Health is funding a major statewide program initiative to provide nontraditional services to those severely mentally ill clients who are most difficult to maintain in the community. The program is based on Assertive Community Treatment principals, modeled after the Program in Assertive Community Treatment (PACT), in Madison, Wisconsin (Stein, Test & Marx, 1975). Four million dollars was invested in 1985 and another two million in 1986. Each site funded is to select fifty of its highest recidivist clients (minimum of three lifetime admissions, at least one of which was in the past year) to receive these special services.

The PACT program is a specific treatment model, which has repeatedly demonstrated success with chronically mentally ill clients. The model uses a team approach, active involvement with the client in his/her milieu, and a focus on teaching life survival skills (cooking, laundry, etc.) and problem-solving techniques through intensive client contacts (daily or more frequent, if necessary) in order to provide community support and to serve as an early warning system to stabilize conditions before crises erupt which require hospitalizations.

Key elements of the model are an assertive, outreach technique and in vivo interaction to increase client involvement and minimize drop-out rates.

As part of the Department's planning process to implement the model, we turned to the literature on knowledge diffusion and planned change to provide suggestions on factors which can optimize adoption of an innovative change in practice (although established research conclusions in this area are lacking). Much of this literature has been based on a research, development and diffusion model which assumes a rational basis for change adoption (Havelock and Benne, 1967; Fairweather, Sanders and Tornatzky, 1974). Thus, facilitative strategies (providing resources like staffing, making time available, physical plant changes, etc.), power/coercive techniques (threats, punishments, rewards, etc.), and information/re-educative methods (understanding of model and its complexity, communication methods, etc.) have often been stressed (Bennis, et al, 1969; Tornatzky, Fergus, Avellar and Fairweather, 1980). Other writers have added to this the necessity of considering circumstances, timing, and resistances likely to be encountered, such as value compatibility, organizational motivation and other non-rational factors (Davis, 1978; Zaltman and Duncan, 1977; Rothman, 1974). Oftentimes, however, the focus is at the agency level (cf. Davis) and not on the individual practitioner who must change his/her workstyle and habits.

In implementing this new program we utilized as many of the planned change techniques as were available to us. Information was provided through statewide and regional conferences. The complexity of the change necessary was balanced by the fact that the ACT program was based on a well-defined and proven model; written documentation of its philosophy and procedures was available and distributed to participants. Peer consultation was provided vis-a-vis conference presentations and opportunities for face to face technical assistance. Agencies were provided sufficient resources to fund the new services and for staff to obtain additional consultation from peers running similar program models. Agencies had flexibility in selecting a start-up time most compatible with their own circumstances and in modifying the model (within limits) to accommodate their own program's felt need. However, despite these efforts, substantial difficulties were still encountered in ensuring that funded programs adhered to the basic model, the intended target population and the intervention approach.

This experience of providing consultation to agencies in order to produce successful implementations of the model has provided insights into *why* such non-traditional, CSP-based programs are *not* sweeping the country and effecting hospital reductions according to results already demonstrated in the research literature. It is our conclusion that getting staff of traditional community mental health programs to treat chronically mentally ill clients appropriately is like putting square pegs (the clients) into round holes (the existing programs). What is described in this paper is the experience one program consultant encountered in working to change programs to provide more appropriate services for chronic clients, i.e., "making square holes for square pegs." These efforts to affect ap-

propriate programmatic changes were all in the context of a community mental health agency having adequate expansion funds to serve the target population, having a model around which they could adapt their own interventions, and having the flexibility to get around the usual bureaucratic barriers. In other words, resources, knowledge, and paperwork were *not* constraints or excuses (as is suggested in the rational approach to planned change).

The "Square Peg"

Understanding the problem first requires a description of the square peg, the high recidivist, chronically mentally ill client who is the target of this intervention. NIMH/CSP has indicated that their criteria for chronically mentally ill (CMI) persons includes severe disability resulting from mental illness plus impaired role functioning meeting at least two of the following criteria: (a) being unemployed or with markedly limited skills and a poor work history; (b) requiring public financial assistance and possibly help in its procurement; (c) having severely limited ability to establish a personal support system; (d) requiring help in basic living skills; and (e) exhibiting inappropriate social behavior necessitating mental health or criminal justice interventions (National Institute of Mental Health, 1982). Additionally, The Bridge, a program in Chicago which focuses on the highest recidivists (treatment failures) among the chronically mentally ill, characterizes their clients as disengaged, unmotivated, with disorganized or rootless lifestyles, reluctant to comply with or failing to benefit from the usual pharmacotherapy approaches, unable to feel comfortable in traditional, structured, professional treatment settings, with a need for interdisciplinary services which are largely inaccessible to them (Witheridge and Dincin, 1985). The National Mental Health Association (1985) adds to these characteristics: Powerful dependency needs, lacking self-confidence and self-esteem. In short, these are multi-problem, isolated clients who are turned off to professionals and have had failure or other negative experiences with service systems.

The "Round Holes"

Traditional methods of outpatient service delivery in community mental health are what are being described as "the round holes." In this tradition, therapists deliver one-on-one, insight-oriented, verbal therapies. This is usually based on clients indicating what their discomforts are, working with their feelings that are causing these discomforts, and defining the root causes of these feelings (often from parental interactions or other early life experiences). And so, having knowledge of the what and the why of their feeling states, clients are able to confront their present situation—to alter expectations, to realize their fears are not realistic, etc., and therefore, come to a more adjusted, satisfactory solution. This is the model that is still reflective of much professional mental health education in clinical therapeutic techniques and one that relies on clients being

reasonably intelligent, insight-oriented, well-educated, and functioning well enough at least to show up and pay for weekly individual therapy sessions over a long period of time (Stern and Minkoff, 1979).

Putting Square Pegs in Round Holes

As is obvious from the two previous descriptions, high recidivist CMI clients have neither the resources nor the motivation to benefit from the traditional approach, and in most respects they are more needy than clients who successfully utilize traditional outpatient services. These services do not meet the very specific needs of the CMI client nor are they usually acceptable to them. The results are likely to be frustrating and demoralizing for the clients and for the service providers. As an example, in one urban mental health center, of thirty-nine catchment area residents who were hospitalized for one month, nineteen (forty-nine percent) refused to even accept a referral to the CMHC (have an appointment made for them). Of the twenty residents who accepted service, only five, or thirteen percent of the original thirty-nine showed up for the first appointment. No statistics were kept on the percentage showing up for subsequent appointments!

A record review study of aftercare clients served in a traditional outpatient therapy mode suggests some reasons for these high drop-out rates. Progress notes are notably absent. Instead, there is letter after letter to clients stating:

> Dear _____
> You missed your last appointment of _____. Your next regularly scheduled appointment is _____. Please call my office as soon as possible if you will be unable to keep this appointment.

When high recidivist, chronically mentally ill clients do keep their appointments, the content of the therapy session may be quite irrelevant to their needs. This case example, taken from the aftercare service records of one urban CMHC (not involved in the present effort) is sad, but not atypical.

Ms. Johnson was a single parent, in her thirties with two elementary school age children. She had been hospitalized three times in the past. She came in to her regular therapy session, agitated, telling of how the previous day her mother had tried to have her committed. (This was not a delusion; she brought the petition with her.) Her mother had called the police, told them her daughter was crazy and was trying to kill her children. The police came to Mrs. Johnson's house to pick her up and take her to the hospital for an evaluation. Mrs. Johnson had to find a neighbor to care for the children, manufactured an excuse as to why she was going off with the police, and spent the entire day at the hospital, finally convincing them that she was not crazy. Mrs. Johnson came in to her therapist to get help, asking what could she do about her mother? This was the second time her mother had done this and the situation was likely to recur since there was an economic basis for the behavior—her mother saw this as a way to get her hands on the AFDC payments her daughter was currently receiving. In response to Mrs. Johnson's agitated, distraught plea for help, the therapist took out the local phone book, looked up the phone number for Legal Aid, gave it to the client and suggested they might help her. She then proceeded with the scheduled topic for the session, Mrs. Johnson's hostile, angry feelings towards her mother, stemming from her feelings of neglect as a child.

We are not imputing this therapy approach in general. Within the traditional mode, the therapist's approach could certainly be justified. That is, when the focus of therapy is on interpersonal dynamics and its historical roots, it should not be distracted by current interactions that are only manifestations of deep-seated problems. According to this perspective, dealing with the current problem would only be putting out a brush-fire which is likely to spread or occur in another location because the ground below is actually igniting the blaze. Thus, the therapist quickly deals with the current problem utilizing the client's resources and coping abilities to produce a short-term solution, and then returns to focus on the underlying cause—the client's relationship with her mother in childhood.

However, with chronically mentally ill clients, their resources and skills are inadequate. So, Ms. Johnson is unlikely to follow up on the Legal Aid referral. Or, even if she does, Legal Aid might be reluctant to give much attention to a former psychiatric patient. Thus, Ms. Johnson will probably become increasingly agitated in response to the situation, creating stress for her children, with the possible results of putting *herself* back in the hospital!

This is the usual way of doing business in the aftercare service system which was the focus of the Department's change efforts. Even with adequate resources, the task is difficult because of ingrained values and practices, acquired as part of the clinicians' professional education (Stern and Minkoff, 1979). What follows is a description of experiences in providing consultation to one urban program to initiate an assertive community treatment (ACT) approach within an agency, whose director and staff were thoroughly enmeshed in providing traditional outpatient services to all their clients, regardless of the client's capability to profit from this method of treatment. We have renamed this program Central Demonstration Project or CDP.

Implementation of the Model & Problems Encountered

Central CMHC was selected to receive funds to implement an Assertive Community Treatment program because of its high utilization of the State hospital and recidivism rates close to eighty percent. Because this was a new initiative, this service was set up as a demonstration project (CDP), with the understanding that if the project could demonstrate that clients in CDP had fewer hospitalizations than a control group, it would be continued as an ongoing program, part of the county's service contract with the state. Thus, CDP had a well-developed evaluation requirement, including submission of quarterly progress reports. After about six months, it was clear that CDP was not delivering the services expected, nor addressing services to the intended population. Consultation and technical assistance from state level staff were required over an eighteen month period to try to get this project on the right track.

Several types of problems interacted to make the process of implementing the ACT program extremely difficult. These problems can be characterized as system-level and agency-based. The system-level problems were a result of charac-

teristics of the public mental health system and the structure of the Department's new program initiative.

The first system-level type of problem resulted from the Department's *accountability structure*—or more appropriately from its absence. It was not clear, for example, who was really responsible for the implementation of the program. Furthermore, the Department never made clear the criteria that would be used to determine whether or not sufficient progress had been made in implementing the model, and thus whether or not funding would continue. The second type of structural problem related to aspects of what might be called the *incentive structure* of the new program initiative. For example, there were really no fiscal incentives to adopt the new model—once the agency was selected they were told they had the money with apparently no strings attached. This relates directly to another feature—that there were no disincentives for the agency doing what *it* wanted to do, rather than adopting the intended model. In fact, major modifications in the inappropriate way the model was being adopted were not made until the Department threatened to reduce or eliminate funds—despite the fact that the agency's prior efforts were clearly not working.

These structural problems at the system-level significantly contributed to other agency-level problems, notably with the supervisor of CDP and staff hired to carry out the project. The agency director's overall reluctance to adopt a program which would require significant changes from the status quo helped to reinforce the staff's reluctance to carry out a PACT model. This reluctance has been discussed frequently in literature dealing with work-force issues of serving the chronically mentally ill (e.g., NIMH, 1982). For instance, preservice training for mental health professionals which still focuses on therapeutic techniques designed for better-educated, verbal and insightful clients, rather than a more severely disabled group. Another impediment is professional values which emphasize aspects of the work environment that are *not* congruent with the outreach-oriented approach needed for chronic *MI* clients: examples of such aspects are a spacious, comfortable office in a good location; reasonable nine to five working hours, five days a week; clients that identify with, look up to and feel grateful to their therapists, etc. These impediments stemming from professional training, attitudes and value systems in turn produce specific difficulties in staff capabilities and willingness to carry out a nontraditional service approach for chronically and severely mentally disabled clients. Specific examples of these difficulties from the CDP are described below.

Staff and supervisors repeatedly demonstrated a *reluctance to serve the most difficult and chronic cases*—which were to be the focus of CDP in order to effect hospital use reduction and to replicate the PACT approach. This reluctance was seen from the outset of negotiations on the intervention approach. When the PACT program and its documented effectiveness on high recidivist clients were first described to the agency, the supervisor reacted strongly—indicating that this

client group consisted of violent, uneducated substance abusers who lived in the most dangerous part of the catchment area and her staff would refuse to deal with them, particularly using a home-visit model. She identified an alternative priority group, which she contended could still achieve the intended reduction in hospital utilization and proposed to target clients with two or fewer prior admissions, who still lived with their families. Intensive intervention (modeled after the approach of Anderson, Hogarty, and Reiss, 1980) with these clients and their families could alter the potential for a chronic career as a mental patient and would promote efficiency by using families as care extenders and decreasing the need for home visits.

While this seemed like a reasonable approach on paper, its implementation did not produce the needed volume of admissions to CDP. However, so strong was the staff's orientation to serving a less disabled group, they continued to use these entry criteria despite the fact that three months of operation, with a full staff complement, yielded only three clients. Clearly, a low recidivist group with family involvement could not be found among a population brought in for admission to the state hospital. However, the agency did not change its approach until the State Department intervened and threatened to withdraw funds unless entry criteria were broadened and clients diverted from hospitalization so that the program would be filled.

Later on in the project's operation, a specific example of this reluctance to serve the severe and difficult clients again occurred. With a change in entry criteria, more high recidivist clients were now enrolled in the program. In reaction to staff's difficulty in serving them in the usual way, the project proposed stringent exit criteria. All clients would be automatically discharged at eighteen months (whether or not the treatment goals had been achieved). Furthermore, clients and/or families who failed to attend services regularly or cooperate with treatment personnel would be terminated immediately. The project was told that these exit and termination criteria were completely inappropriate, indicating a misunderstanding of the program's intent and philosophy. The point of assertive community treatment is to do outreach and provide in vivo services. Lack of cooperation and irregular attendance is common with chronic clients. If the client/family fails to cooperate, this is not considered *their fault*, but rather the problem of the program which needs to make more assertive efforts to keep in contact with the client and provide *appropriate* and *acceptable* services. Furthermore, arbitrary termination at eighteen months was not acceptable since many clients needed lifelong contacts. On the other hand, clients who could move into greater independence from the project should be encouraged to do so without waiting eighteen months.

A second major area of difficulty was the staff's tendency to *deliver services in a way which met their own professional needs and desires,* but not necessarily those of the clients. In terms of the overall intervention and in dealings with individual

clients, the project made decisions and provided services solely based on clinical traditions and/or professional opinions, rather than tempering these views with the documented needs of clients, *their* preferences or opinions. This professional blindness was seen at the program outset when the supervisor suggested combining an Anderson family-centered model for treatment with a PACT approach. Clients and families would be enrolled during hospitalization and then followed into the community providing outreach and in vivo treatment to clients and a psychoeducational support approach to families. The project was given tentative approval to proceed with this model, but told that before implementation began, hospital utilization of the target group would have to be documented to prove that, with only the traditional services provided, many of them *did* become chronic clients. Agency staff dutifully carried out the documentation which showed that clients with families were unlikely to *ever* return to the hospital! However, the implication of this finding was lost to the agency staff. They were shocked when told that this meant their program would be providing more intensive services to people who did not need them and they would have to find another target group or another intervention. The compromise worked out was to keep the same target group but start the intervention at the Crisis Center, diverting clients from ever going to the hospital and so achieving the required hospital reduction. In this example, the program was developed to meet the needs of the professional staff (serving clients and families with a service approach that interested them), rather than being tailored to the needs of a client group which constituted the highest hospital users.

On an individual client level, the same orientation to professional opinions and lack of consideration of client-expressed needs and preferences was also seen. In the third quarter, a case study was presented of one of the staff's most difficult clients. This woman had been in the community hospital nearly sixty days when CDP, hospital staff and family decided she should go into an adult foster care placement following discharge. She refused because no one had talked to *her* about the placement and she wanted to go home to her parents. The result was the woman was transferred from the community hospital to the state hospital where she underwent a much longer stay than was necessary. CDP staff were told that the outcome of the case might have been improved if there had been more and earlier sensitivity to the client's needs, communication to understand the client's perspective on her problems and direct client involvement in treatment planning.

A third major area of difficulty observed was the *staff's reliance on office-based practice methods and reluctance to get out into the field.* Even though the PACT model clearly utilized an outreach approach and provision of services in the client's own environment (in vivo) rather than the mental health office, staff made major alterations in the program's operation to revert to their office base. For example, when the program began, the model specified contacting clients at the Crisis Center, enrolling them in the program, beginning service provision at

the point of crisis and, thereby, averting hospitalization. Instead, the first quarter's progress report indicated that agreements with the participating hospitals and Crisis Center focused only on the team's involvement in discharge planning. There was no mention of diverting clients away from the hospital before admission. Eligible clients in crisis who were not hospitalized were processed through the usual referral system. That is, the team received a packet of information about the referred client in the mail and proceeded to contact these clients regarding participation in the project, *several days later*—clearly not engaging the client in crisis when an offer of help might be most acceptable and useful. Furthermore, even for hospitalized clients, the team's point of contact was within seven days *after* discharge. Both of these practices were contrary to the PACT approach of actively reaching out to clients, establishing rapport with them while in crisis, and doing so in the client's environment, rather than expecting the client to follow-up on referrals by showing up at the therapist's office. The failure of this approach was clear: In three months of operation only three clients had been successfully enrolled. Despite this, staff would have continued these efforts had they not been told that major changes were necessary.

Later in the project's operation, the same reluctance to get out in the field was also noted. In the second quarter, staff were told that the project needed to have in place arrangements for short-term emergency housing, to be used as a hospital diversion for those clients who had no domicile of their own or inappropriate living arrangements. In the next quarterly report, project staff provided us with a list of *shelters* for homeless persons that they intended to use. The project was told that shelters were not protected, structured or intensive enough to meet our clients' needs, often anxiety-producing in and of themselves and, above all, usually full! They were told that they were to get out into the community, seek out and arrange for appropriate alternatives, e.g., rooms in hotels, board and care homes, YM/YWCA, respite beds in adult foster care, etc.

A final problem noted in implementing CDP was staff *lack of awarness of using community resources* to meet client needs and/or a variety of treatment approaches. In an outreach-oriented, in vivo treatment method, value is placed on integrating the client into his/her community and utilizing generic services available. Thus, clients may be enrolled in adult basic education, community colleges, volunteer programs, city recreation programs, etc. Often this is done with staff supporting or even attending with the client. Instead, with CDP we saw that staff were not considering what community resources were available and, so, either not meeting their clients' needs, trying to create the needed resources themselves, or inappropriately using the most obvious resources. An example of the latter was the intended use of shelters for emergency housing needs. Examples of the former two problems involved female clients. For the third quarter report, staff were asked to indicate to what extent clients were involved in meaningful daytime activities. The report indicated a number of different programs being used for all but five women. Although they were willing and needed some out-

side activities, these women were at home with small children and so the staff did not know what to do about this. State staff had to point out to them that since they had flexible funds to meet client needs, they could set up a mother-toddler group at the Center or pay for slots in some neighborhood nurseries.

Another example of lack of awareness of community-based and multiple treatment approaches was seen later in the project as well. This involved a case study of a woman with a six month old child. The staff had enrolled this women in partial day programming, which included getting a GED through adult basic education and prevocational training. However, no attention was being paid to the assistance she needed as a first-time mother, parenting education, infant-mother bonding, etc. At our suggestion, arrangements were made for services from an infant mental health specialist in a community agency.

CONCLUSIONS AND RECOMMENDATIONS

Certainly nontraditional service programs for severely disabled clients have been successfully implemented in many settings without the problems encountered at the community mental health center examined in this case study. However, development of an original model *may* contain more favorable circumstances than a replication, e.g., the research aspects of the original models produce more willingness to take risks and enhance the motivation of agency staff to "prove something." Also, agencies willing to pilot an untried model are probably highly motivated to begin with—they are the ones seeking out funds for a service program that they have developed themselves out of a felt need to solve a problematic situation.

Preselecting an agency to receive funds for this demonstration based on the funding agency's needs and not on the agency's own needs and motivation certainly appeared to be a mistake with the CDP. Other mistakes made with CDP were noted above, such as, providing no clear sanctions or administrative authority concerning program failure or noncompliance, and selecting an intervention based on the preferences of the agency staff and not on the needs of the target population. It is interesting to note that these mistakes and the traditional orientation of the agency's administration and program staff apparently had greater effects on program operations than the things that were done right; e.g., providing a specific model for the intervention, clearly specifying outcomes expected, allowing flexibility in implementation, providing written guidance on the model, intensive inservice training and visitations to similar programs, and peer consultation by a clinical expert from the original model.

The experiences from this case consultation do support some of the literature on knowledge diffusion. First, the importance of power-coercive (e.g., clear sanctions) as well as re-educative techniques (e.g., a clear model, neccessary tech-

nical skills, and appropriate communication techniques). Second, the fact that implementation was still difficult, even though resources were amply available, corroborates one of the findings of Fairweather (1973) in his efforts to disseminate the Lodge model—the fact that the financial capability of a hospital had no bearing on its adoption of the innovation. Clearly, there was too much reliance on strategies based on a rational model of change. More attention should have been paid to the clarification and reconstruction of values (as suggested by Bennis, *et al.*, 1969) and the organization's commitment to change (Zaltman and Duncan, 1977). The conclusion of Tornatzky *et al.* (1980) concerning innovations and social process may be warranted: *All* complex innovations which demand extensive organizational dislocations are difficult to implement.

However, perhaps the most important lesson to be learned from this demonstration project case study is that nontraditional services for the chronically mentally ill are difficult to replicate: Staff in many community programs will tend to gravitate towards traditional methods, those congruent with their training and experience. These traditional ways do *not* include a team approach, in vivo, out-of-the office service delivery, an emphasis on concrete problem-solving, action-oriented services rather than insight-oriented, verbal therapies, etc. *Any* replication, no matter how much positive groundwork has been laid, needs to include a carefully developed evaluation plan and methods of documentation and monitoring that utilize multiple approaches—quantitative and qualitative, process and outcome, traditional and innovative. Many of the problems from CDP would not have been identified so quickly if there had not been a comprehensive evaluation plan which involved quarterly production of reports and face-to-face meetings. The evaluation plan included reporting very specific process components (e.g., content and execution of agreements with other service agencies, description of plans to meet emergency housing needs, daytime activities, etc.), quantitative information (e.g., client characteristics, service utilization, hospital length of stay and readmissions, baseline utilization review, etc.), and qualitative data (case studies quarterly of two successfully served and two problematic clients). Also, after each evaluation meeting, a feedback report was sent to the project, summarizing the program and/or reporting modifications agreed upon and additional or changed requirements for the next evaluation report.

Based on this experience, we conclude that many replications of innovative models for the long-term mentally ill will need intensive supervision and support over a rather long period of time. Perhaps many of these programs, like many of the clients they are designed to serve, will need lifetime case management and in vivo treatment (technical assistance)! To save the mental health of evaluators and program consultants, a team approach is also recommended to agencies for implementation. After all, it's not easy making round holes square!

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