A Review of and Recommendations to Build Evaluation Capacity for Programs Funded by the Champaign County Community Mental Health Board (CCMHB)

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A Review of and Recommendations to Build Evaluation Capacity for Programs Funded by the Champaign County Community Mental Health Board (CCMHB)

Background

The Champaign County Community Mental Health Board (CCMHB) aims to build evaluation capacity among funded agencies. The current report summarizes findings from an assessment of current evaluation capacity, a summary of Board and Agency priorities, and a plan and set of recommendations to build such capacity. This report is informed by:

a) a retreat held with CCMHB members
b) a review of performance outcome reports submitted to the CCMHB in 2015
c) meetings with funded agency leaders (the Evaluation Subcommittee of the Mental Health Agencies Council)
d) interviews with Board members
e) a survey of funded agencies and programs
f) a review of literature on building evaluation capacity

The report includes three segments. The first addresses the current state of evaluation activities among CCMHB funded agencies. The second summarizes the priorities as expressed by the board members and funded agencies. The third makes specific recommendations for implementation in the 2017/2018 fiscal year.

Part I
Current Evaluation Activities

Two sources of information were used to assess current evaluation activities. The first was a review of Performance Outcome Reports (provided by all funded agencies at the end of a fiscal year). The second was a survey of agency leaders aimed at assessing current evaluation approaches in each funded program, barriers to evaluation and evaluation priorities.

Performance Outcome Reports

Performance Outcome Reports provide a useful window into CCMHB funded agencies current evaluation capacity. These reports were reviewed with attention the types of issues programs addressed, the nature of current evaluation activities and how evaluation findings were shared via reports.

All Agencies Engage in Evaluation Effort

All agencies engaged in evaluation activity as required by the CCMHB and other funders. However, there was considerable variation from program to program regarding the nature of these activities. Not surprisingly, this reflected the different foci of funded programs, but it also reflected different agency capacity to pursue evaluation.

Program and Service Structure is Varied from Program to Program

The Champaign County Mental Health Board (CCMHB) funds 27 programs with an impressive array of primary services provided (figure 1). Individual counseling is the most common primary service provided by programs (at 26% or seven programs total). Assessment, case management, substance-abuse treatment, and community engagement/social support were identified as primary services by three programs each. Group therapy, parenting education, resource referral or benefits management, transitional living, medical care, employment assistance, advocacy, and prevention are each the primary services offered by one program.

Figure 1: What is the primary service the program provides to clients?

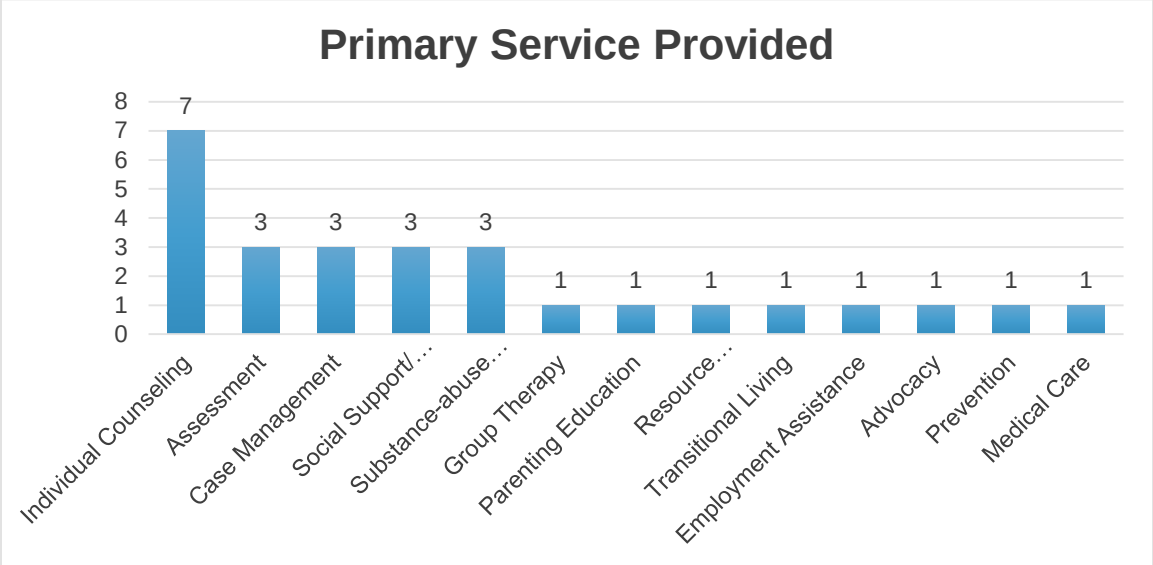
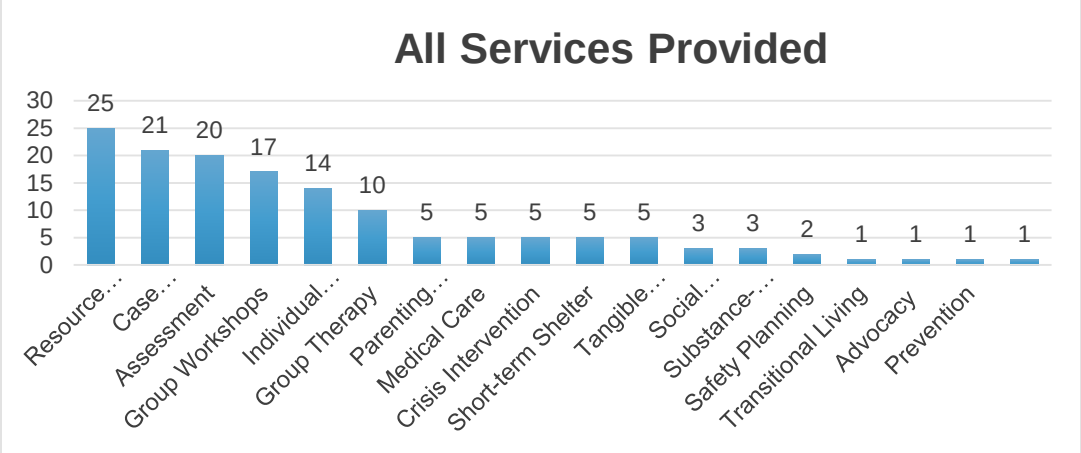


Figure 2: How many different programs provide each type of service to clients?

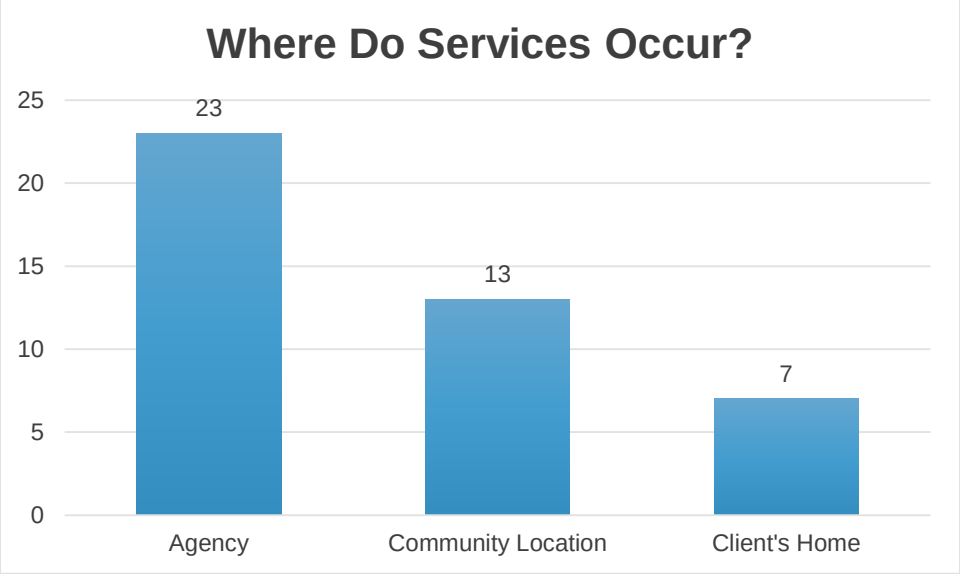


In addition to the primary service identified above, the majority of programs offer other, complementary services. Figure 2 (above) describes the number of programs that offer each type of service. Twenty-five programs offer some form of resource referral or benefits management to clients in addition to other services like individual counseling or parenting education. Similarly, 21 programs offer case management services, 20 offer assessment, 17 offer group workshops (e.g. a one-day seminar on a specific topic), 14 programs offer individual counseling, 10 programs offer group therapy, four programs each offer parenting education, medical care, crisis intervention, short-term shelter, or tangible resources, three programs each offer social-support/community engagement or substance-abuse treatment, two programs offer safety planning, and one program each offers transitional living services, advocacy, prevention services, or employment assistance.

About 50% of programs that mention providing referrals to outside agencies articulate the types of agencies to which they refer clients; this type of information can be helpful for understanding the resource network that clients are aware of and/or are accessing.

Over 30% of programs explicitly identify offering services in multiple languages. Seventy-four percent of programs identify the agency as the primary location of provided services, and almost 60% of programs also offer services outside of the primary location (i.e. services are also provided in the client's home, or a community location like McDonald's, etc). Figure 3 provides a visual representation of where programs are conducting services.

Figure 3: Where do Services Occur?

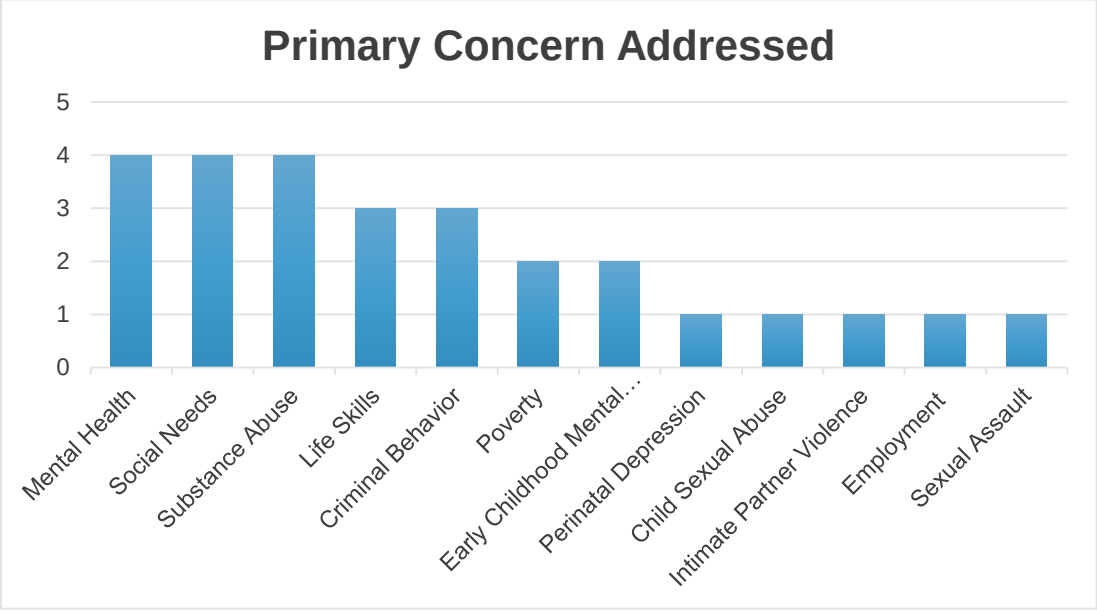


Note: Because a program may engage in services in more than one location, the total frequency of the figure sums to more than the total number of programs.

The target populations of CCMHB funded programs are broad, with no more than five programs (18.5%) identifying the same target population. Five programs target individuals who have been involved in the criminal justice system, with programs serving different needs for this population. The next most common target population is individuals with developmental disabilities, with four programs explicitly serving this group. Next, Champaign County residents in general and Champaign County residents living in poverty are each the target population for three programs, and two programs each serve children in need of early mental health intervention or individuals with mental illness either in crisis or involved in the criminal justice system. Partner violence survivors, mothers at risk for perinatal depression, suspected child victims of sexual abuse or extreme physical abuse, low-income seniors, middle-school students in Champaign County, youth engaging in substance-abuse, survivors of sexual assault, and immigrants or refugees living in Champaign County are populations explicitly targeted by one program each.

As one might expect, given the diverse populations served, the primary concerns that the funded programs address are also diverse. Five programs primarily address mental health, four programs each address substance abuse or social support needs, two programs address independent-living skills, two programs each address early childhood mental health or criminal behavior, and one program each addresses homelessness, intimate partner violence, perinatal depression, poverty, child sexual abuse, employment assistance, and sexual assault as their primary concerns. Consistent with the interconnected nature of these concerns, 21 of the 27 programs also address ancillary concerns in addition to the primary concern.

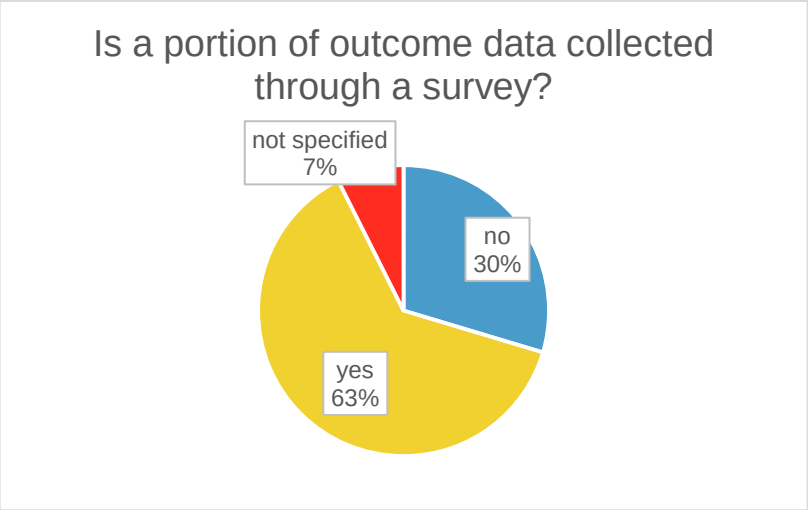
Figure 4: What is the *primary* concern addressed by the program's services?



Outcome Data

Ninety-two percent of programs explicitly mention collecting outcome data, with 63% explaining that at least a portion of outcome data is collected in a survey format (figure 5). One program explicitly stated this information was gathered using a paper survey and two programs indicated they used a combination of methods; a few programs did not give information on how outcome data was collected.

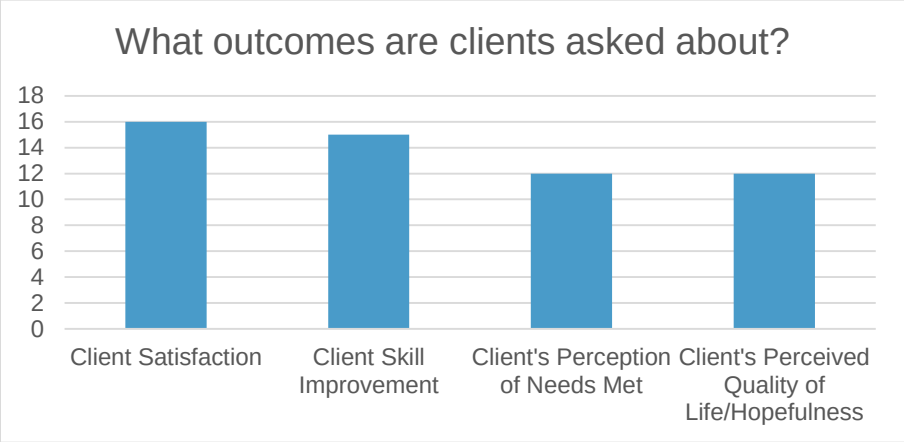
Figure 5: Does the program use a survey to collect any outcome data?



Of the 25 programs that collected some form of outcome data for FY 2015, 16 programs collected information on client satisfaction, 12 programs collected information on clients' perception of the degree to which their identified needs are met, 15 collected information on client improvement in skills relevant to the program intervention (as assessed by changes in measures over time and client self-reports), and 12 collected information on clients' perceived quality of life or hopefulness (Figure 6). It is unclear if data on client improvement in specific domains of life (e.g. employment status, relationship quality) or on symptom management/reduction (e.g. experiencing fewer depressed days) is collected, as it is typically not presented as outcomes.

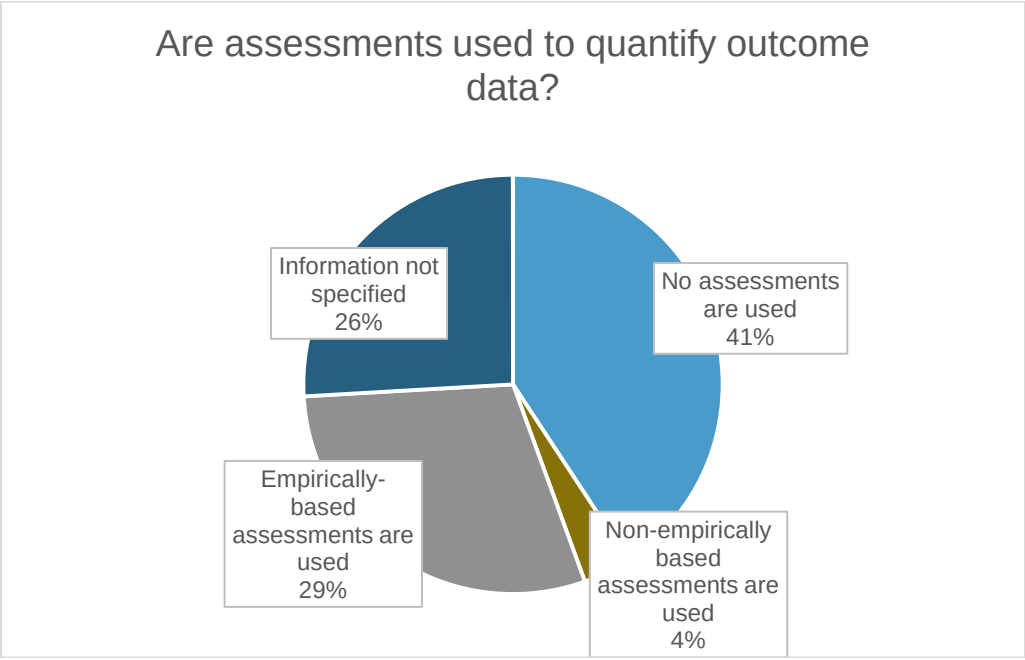
Programs vary with regard to from whom data are collected. Eight programs explicitly stated that for every client an effort is made to contact them to assess outcomes. One explicitly mentioned that *not* every client is contacted for outcomes, and the rest did not discuss this aspect.

Figure 6: What kind of outcomes do programs assess?



As a whole, programs do not specify how many times and in which intervals outcome data is collected; five programs state that they collect outcomes more than once yearly, six programs specify or allude to collecting outcome once yearly, and 13 programs did not clearly specify their process. Eight programs use empirically-based assessments to gather outcome data, one program uses an assessment that is not empirically-based, 11 programs do not use any assessments in their outcome data, and the remaining seven programs are unclear (Figure 7). (By empirically-based, we mean assessments that are standardized and have been shown to be valid for studying the specific topic of interest.) The types of assessments programs use vary from depressed mood scales, alcohol, tobacco and other substance use questionnaires, health behavior profiles, and post-natal depression scales to ages and stages questionnaires and individual needs assessments.

Figure 7: Does the program use any assessments to quantify outcome data?



The majority of programs make some mention of the number of clients served, with only two programs not discussing this aspect. The number of clients served by the program ranges from zero to ten, to 601-1000, with most programs serving between 150 and 500 clients.

The majority of agencies that collect outcome data from client surveys draw conclusions about general service effectiveness from client reports of satisfaction. Few agencies report using outcome data to engage in quality improvement practices or to draw specific conclusions about service effectiveness. Similarly, programs typically do not report information about measuring change over time.

Building on agencies current data collection efforts will be integral to create a climate of within-program evaluation. The data suggests that programs tend to be limited in the type of data collected, with a heavy reliance on number of clients served, demographics, and satisfaction; this may be a response to the type of information traditionally valued by funders. Because satisfaction surveys tend to be poor indicators of program success (Stallard, 1996), incorporating more empirically-sound methods of outcome evaluation and building internal confidence for evaluation will provide a more accurate representation of program impact and a more solid foundation for program self-reflection and continuous quality improvement.

Survey of Funded Agencies

Stakeholders from 25 programs funded by the Champaign County Mental Health Board in the 2016/17 fiscal year completed an online survey. Respondents answered general questions about typical program evaluation processes and outcome goals. The following summarizes findings from the survey.

Current Processes
What is collected?

All programs surveyed (n=25) endorse collecting some form of outcome data; notably, it appears that most programs consider any data related to the client or services received as an *outcome*. Similarly, many programs report information on case conceptualization and assessing client needs/planning as assessing client outcomes. Clarity regarding what constitutes an outcome versus a process may help communicate evaluation expectations. For example, a program with a primary service of assessment might appropriately consider completed assessments as an outcome. Evaluation capacity building efforts will need to acknowledge that what might reasonably be considered an outcome could depend on the goals of the program, and what is an outcome for one program might not be for another.

The most common type of information collected by programs is client satisfaction (n=20 programs, 80%). Over half of programs endorse collecting information on client perceived quality of life and education status (n=17 and 13 programs respectively; 68%

and 52%), while about a third of programs endorse collecting information on either substance use (n=9, 36%), prevalence of symptoms as a way to track reduction (n=10, 40%), employment (n=10, 40%), contact with the criminal justice system (n=9, 36%), housing (n=8, 32%) or health status (n=8, 32%). In addition, individual programs endorse collecting other information relevant to their specific goals such as: achieving personal goals, improvement in relationships, completion of substance abuse treatment programs, increased knowledge in specific domains, self-advocacy skills, breastfeeding and immunization initiation, and assessments of family cohesion.

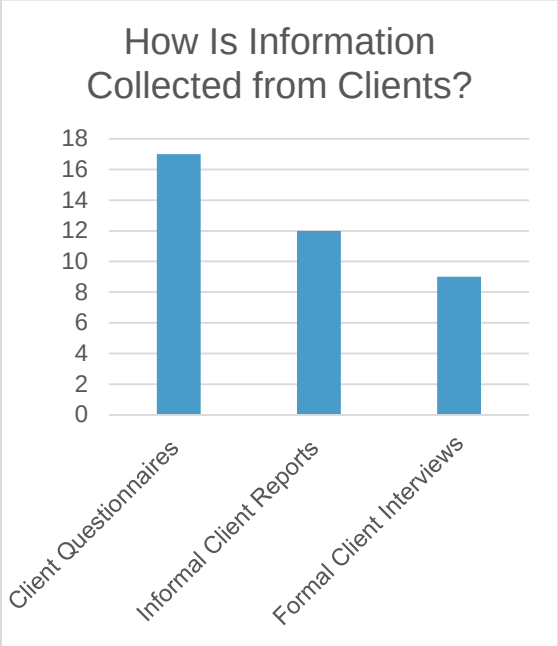
Programs that are unable to collect specific client-related outcomes because of the nature of their service often collect other types of information; these data are most often related to program processes (e.g. number of calls completed, number of referrals made, number of mental health assessments completed). This is a relatively uncommon occurrence for programs funded by the CCMHB, and typically happens in those services that either do not see clients directly (e.g. Self-Help Center) or that are intended for temporary relief as opposed to regular, sustained contact (e.g. Community Elements Crisis/Access/Benefits center).

Other types of process information gathered is relevant to a specific service; examples include: a) client success in receiving an order of protection, b) response time to crisis call, c) number of mental health assessments completed on same day of appointment, d) number of successful acquisitions of benefits, e) frequency of use of services, f) number of clients who leave before completing the program, g) tracking those who leave and return, h) tracking number of clients who move between levels in the program, i) effectiveness of presenter (for educational/training approaches), j) specific information from the referral source (which might be court, probation/parole, DCFS, etc.), and k) substance abuse screenings/assessments. Programs endorse seeking additional process information related to: how clients are recruited (n=13 programs, 52%), client attrition/dropout (n=13, 52%), type of clients served (n=17, 68%), barriers to treatment (n=11, 44%), common problems in the program (n=17, 68%), and program strengths (n=19, 76%). Individual programs also endorse collecting information on other topics, such as service gaps in the community and numbers related to calls coming in and group topics sought.

How is information collected?

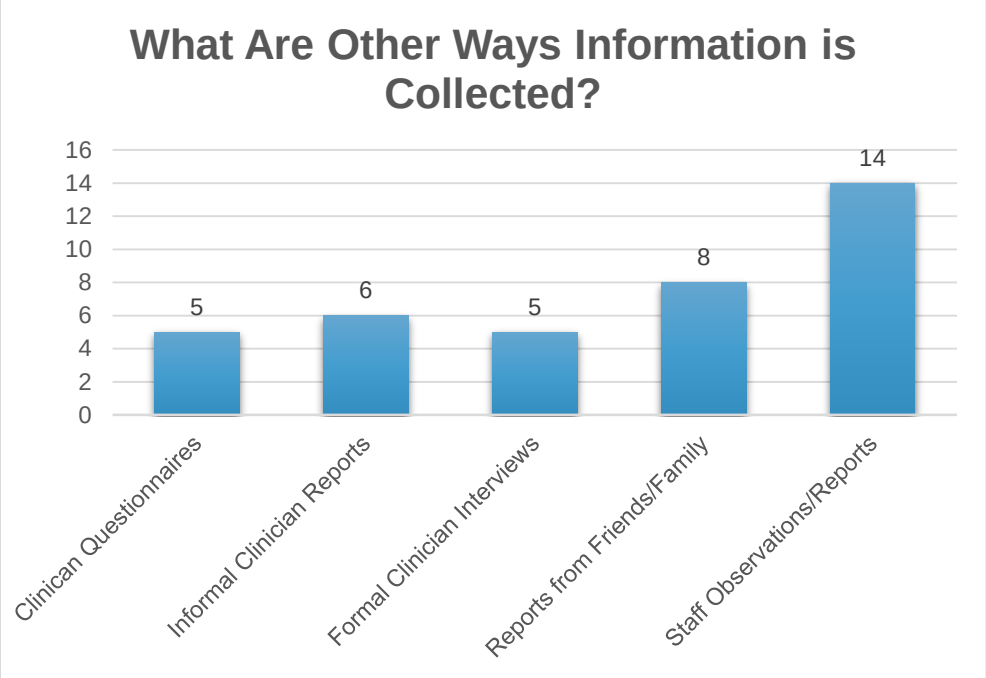
Programs collect information in various ways, with a heavy reliance on receiving information directly from clients; this type of self-report data is regularly used when assessing both client outcomes and program success. Seventeen programs (68%) endorse seeking information through at least one client administered survey or questionnaire (typically a paper questionnaire given directly to the client); 11 programs (44%) use two or more of these assessments. Additionally, programs rely heavily on informal client reports (n=12, 48%) and formal client interviews (n=9, 36%) to assess outcomes (Figure 1).

Figure 8



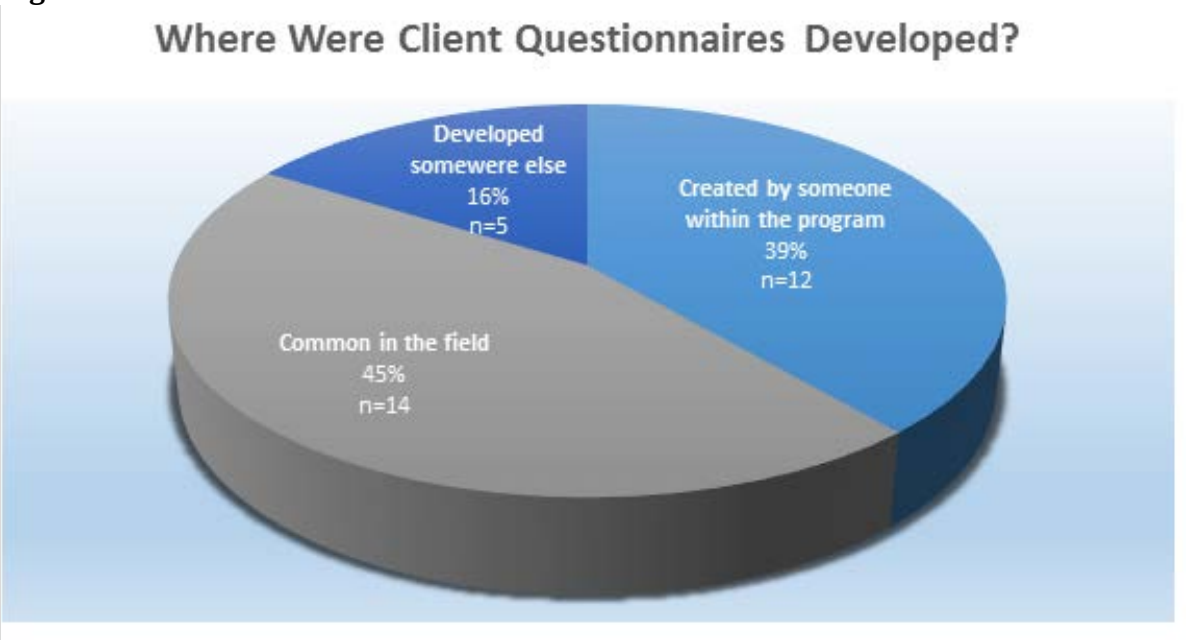
A much smaller group of programs utilize formal clinician interviews (n= 5 programs, 20%), informal clinician reports (n=6, 24%), clinician surveys/questionnaires (n=5, 20%), and reports from friends or family members (n=8, 32%), though over half endorse assessing client progress through staff observations and reports of client behavior (n=14, 56%) (Figure 2).

Figure 9



Of the 31 client questionnaires discussed in the survey, 12 are measures created by someone within the organization or program (39%), 14 are measures endorsed by programs as common to their field (45%), and five are measures that were developed somewhere else (e.g. from an accrediting agency or funder; 16%). It is likely that many of the measures endorsed as common to the field are empirically-based measures with strong research support; if this is the case, it seems that only about half of programs are using client questionnaires with demonstrated validity (Figure 3).

Figure 10



With the exception of some type of client satisfaction survey, there is not a large amount of overlap between the assessments that programs are using; this is likely due to the fact that programs have diverse target populations and discrete outcome goals. Additionally, many programs appear to lack a consistent, systematic process for collecting data; there appears to be little regularity both within and between programs as to when evaluative information is collected.

What is required by funders?

Most programs endorse external funders requiring the use of specific measures or reported outcome information (n=17 programs; 68%). The type of requirements vary by program and funder, but generally fall into two categories – information about who is served/client status at program entry and information about client outcomes/status at program completion. Examples of required information include the number of clients, incidence of client contact with criminal justice system, number of clients with a disability, client employment status, the number of clients who achieve specific goals specified in the grant application, and pre and post scores on assessments.

One program describes one way of funder engagement, explaining “Through the application and contract process, each funder identifies/suggests parameters for outcome measures on either individual or program evaluation functions. Within those parameters, our agency identifies goals [or] outcomes and reports to each funder consistent with their requirements.”

How is outcome information used?

There is also some evidence that some funded programs actively use evaluation data. One program articulates that collecting information related to both client outcomes and larger program policies directly facilitates change, as it “helps address patterns [for an] individual, as well as overall programmatic patterns. This identification of patterns then helps us adjust either the individual’s programming or the overall program for more success in the future.”

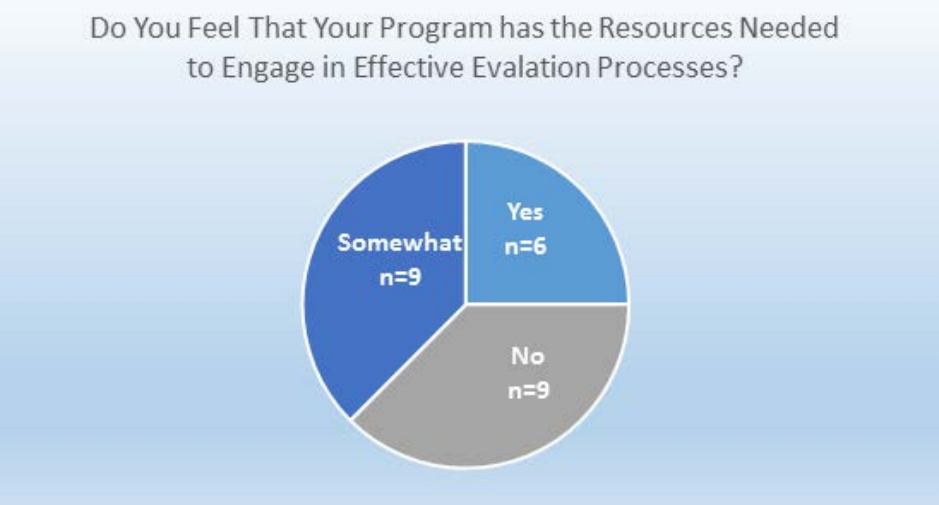
One program explains their conceptualization of the importance of outcome information, noting “Our primary foci are on our clients’ safety, and whatever [a] client may need to be able to take care of herself and her family on a sustainable basis. These needs are identified by each client through self-determination, but her goals and needs measure our success.”

Programs endorse sharing outcome findings with many different audiences. The majority share findings internally with program leadership (n=21 programs, 84%), administrative staff (n=17, 68%), and clinical/therapeutic staff (n=17, 68%), and externally with funding agencies (n=20, 80%) and other agencies (n=8, 32%). Twelve programs (48%) also specify sharing outcomes in additional places, including agency governing boards, Champaign County Juvenile Justice, boards of directors and accrediting bodies, and in annual reports.

Barriers to effective evaluation

Interestingly, while the overwhelming majority of programs identify current evaluation processes as consistent with program goals (n=23 programs, 92%), most also identify a lack of financial resources and staff time as inhibiting effective programmatic evaluation processes. Additionally, over a third of programs rated a lack of staff capability as a barrier to evaluation (n=10, 40%), and close to the same percentage similarly rank a lack of technology (n=8, 32%). When asked the general question, “Do you feel that your program has the resources needed to engage in effective evaluation processes”, nine programs endorsed ‘no’ (36%), nine programs endorsed ‘somewhat’(36%), and six programs endorsed ‘yes’ (24%) (Figure 4).

Figure 11



Program survey respondents identified many specific barriers to evaluation, including: a) managing multiple shifts of staff which can impact the distribution and receipt of communication; b) poor response rates from clients once they are disengaged from services or services are complete; c) finding the right evaluation tools; d) cumbersome data collection methods; e) a lack of time and resources (e.g., staff); f) a lack of technology; g) unrealistic requests regarding types of data difficult to gather (e.g., community level of public health or mental health outcomes); h) different language from one funder to another regarding the specific metrics that must be gathered; i) lack of knowledge regarding the evaluation process from conceptualization to reporting; j) short-term contact with clients and a desire to avoid burdensome and intrusive processes in a short-term engagement.

Some of these barriers may be connected to concerns for staff morale and the overall quality of services. One program elaborates, "the time it takes to track and report data has impacted staff morale due to it pulling staff away from other work that they need to get done and from time spent providing services to clients. It requires agencies to allot a considerable amount of time and resources to extracting data from electronic systems, staff tracking, recording, and reporting data, and then the time to prepare quarterly reports to report the data. [And] all of this [is] in addition to site visits." Similarly, another program explains "It takes a considerable amount of time for staff to track all of the information, document, and report to satisfy funders. Because most of the programs receive funding from different entities [that] have different reporting requirements and different reporting systems (electronic) it can be very time consuming. Tracking and reporting requirements often result in staff spending time engaged in those activities instead doing the work they were hired to do with the clients. It can lead to low staff morale and turnover as staff oftentimes feel overwhelmed."

Stakeholder suggestions for building evaluation capacity

Aside from requesting funding allocated specifically for evaluation processes, stakeholders suggest that guidance on outcome metrics, training on evaluation, and expert analysis of the process with constructive feedback are helpful ways to improve how evaluation is conducted within programs. Interestingly, these intuitive suggestions are highly compatible with the literature base regarding building programmatic evaluation capacity.

In addition to help integrating information required by different funders, a common program request is guidance in choosing outcomes to assess and measurements to use. One programs asserts "The less cumbersome we can make data collection, analysis, and reporting, the better; lack of resources is a huge barrier to our outcome measures becoming more sophisticated." In addition to assistance with resources, analysis and feedback on current processes, and guidance in choosing outcome measures, one program further describes a desire for a clear benefit to the program undertaking evaluation. This suggests the need to build a climate that values evaluation simultaneously to integrating specific evaluation processes in an organization.

Part II

Evaluation Priorities

CCMHB members and funded agency representatives had many ideas about the kinds of processes and outcomes that could be evaluated in their agencies. Given the diversity of funded programs, it is natural there is diversity in the range of questions funded agencies could pose. Below are a few of the salient and general questions that arose.

What do agencies do and does it work?
CCMHB members and funded agencies both expressed a desire to know if the effort they are engaged in is helpful to clients (outcomes) and if they are "doing what they say they are doing" (process). Not surprisingly, these aims are not easily achieved. Both board members and funded agencies expressed knowledge of the challenges involved in drawing such definitive conclusions with limited evaluation resources. Both CCMHB members and funded agencies expressed an interest in engaging in efforts that were feasible and funded agencies, in particular, were concerned about the potential for unfunded mandates to evaluate that would be difficult to execute. Funded agencies requested that any evaluation mandate be coupled with support to make evaluation efforts viable.

Agencies identified many valuable questions they would like to pursue with sufficient resources. Nineteen (76%) rated evaluation as worthwhile. A positive attitude towards evaluation likely provides a useful starting place from which stakeholders might develop testable questions about program functioning. Programs offered many suggestions regarding specific topics they would like to pursue including: a) client safety and safety

sustainability (e.g. ability of individuals whose safety increased as a result of the intervention to maintain the safety after discharge) ; b) subsequent service delivery access (e.g., emergency room visits in response to crises); c) outcomes for children (in addition to tracking adult outcomes); and d) changes in various aspects of client well-being from before treatment to post-treatment (e.g., mental health; quality of life across life domains; functioning; attitudes and behaviors regarding substance use; employment; access to needed resources; and social support).

Funded agencies also identified important areas as they related to *how* services were delivered including. These can be examined as formative research questions including, for example: a) how consistently clients are presented with services – does everyone get offered the same things? b) are clients satisfied with their choices of and access to services? c) does satisfaction with choice and access vary for diverse groups? d) what barriers to treatment do clients experience and how can they be addressed? e) are clients retained in services and does retention and attrition vary by groups? f) are victims of crime or other trauma getting needs met following crisis intervention? g) to what extent is there follow-through and connection with other agencies following referral? h) how timely are services (particularly those for which timing is critical, for example, in crisis response) i) do clients report subjective experiences of service delivery as characterized by respect? and j) to what extent are clients treated by a continuum of connected agencies? Building evaluation capacity involves helping agencies move from articulating topic areas about which they would like more information, to articulating clear (and answerable) questions. Both are important evaluation skills, but the latter is particularly important. If one thinks in terms of questions to be answered, rather than topics to explore, one is much more likely to attend to precisely what data are collected and how they are collected – from whom, when, under what circumstances, etc. – issues that have major implications for the types of inferences that can be drawn.

How does the CCMHB function as a system of funded agencies?

Many of the questions that CCMHB members posed transcended individual funded programs. For example, some members expressed a desired to understand the extent to which funded agencies (and others in the service array) coordinated their efforts when serving clients. Others expressed a desire to understand whether funding priorities matched community needs. Both of these questions and similar others would require evaluation efforts that are cross-agency and could be pursued in addition to questions asked about the functioning of different programs.

Are there outcomes or processes that could be measured across funded agencies to demonstrate impact?

Both CCMHB members and funded agencies expressed skepticism about the use of any uniform measurement given the wide variety of programs funded and the wide variety of outcomes one might expect. Still, there was an acknowledgement that having some uniform measurement might make a stronger case for the value of the CCMHB funding portfolio. Using common measures is recommended (e.g., Labin, Duffy, Meyers, Wandersman, & Lesesne, 2012), but finding the common denominator across programs is

essential to make this a useful exercise. One possibility is a brief measure of quality of life that might be broadly applicable.

Both CCMHB members and funded agencies recognized the value of establishing the impact of the CCMHB funding portfolio. Labin and colleagues suggest that evaluations should be deliberately designed to grow the impact between organizations (i.e., funded programs) and grantmakers (Labin, Duffy, Meyers, Wandersman, & Lesesne, 2012). Both agencies and board members expressed a desire for guidance in this endeavor, illustrated by one board member's statement "I'd like to know what you guys think about our protocol, or our process for deciding what to fund. I'd also like to have a broad perspective, how what we do fits in the broad community perspective…it would be useful for us to know more about that."

During interviews, the majority of board members articulated recognition of the unique needs and goals of each agency; because of this, many seem to anticipate needing to keep much of the evaluation process individualized. One board member expressed it this way: "Different services require different outcomes, so I don't know how you would [standardize]. Demographic and duration of service [information from all programs for example] would be helpful, but sometimes that's very deceptive and just gives the board a 'handle to whip them with,' which seems unjust. The focus shouldn't necessarily be on how many people they served." Similarly, another board member explained, "Programs that are designed to do a specific thing are different than programs that do so many different things; I don't want to know about the agency as a whole. I want to know what they did with the specific money that we gave them."

Board members had different views about the need to have information about program outcomes versus program processes. One interviewee explained "Because I'm not an expert, I probably want to know more about the outcome than the process. For me, the process is just a check because I'm not a specialist. The question I would pay more attention to would be the outcome- [for example], did things improve, and are people enjoying their lives more?" In contrast, another board member asserts "In these programs, outcomes aren't necessarily measurable- the people are gone before they know the outcome. We take it on faith, so we need to know as much about the process as we can. If there were more follow-ups and we knew more outcomes…if we could get outcome facts, [then] that would be wonderful. [But] most of them do not have it. If some of the [grant] money could be spent on evaluation and finding out what the outcomes are we could get some real surprises."

While recognizing the unique needs and goals of the different programs, board members commonly expressed a desire for some common and systematic framework for reporting across programs. One board member requested "Number one, a rubric, and number two, to look at some things factually- you know, 'this is essential if you want to be part of our funding.'" Another board member suggested the common rubric should link program mission to goals asserting "[It is] important that they have goals, that they know what their mission is clearly, and that they can state it, put it in words." Another board member asked that goals be linked to outcomes, "…doable goals- that expected outcomes are

connected to articulated, stated goals. [The programs] should clearly know what they're doing." Thus, an approach that emerged from the majority of board members might involve requiring programs to articulate explicit mission or goal statements, which guide the choice of program processes that are then linked to measurable outcomes. Such an approach would help both program staff and CCMHB board members understand program functioning.

In addition to facilitating a common framework for all programs, there was a sense that such an approach would help to focus the information that the board gets from programs. "We are almost getting too much information, and it's overwhelming. We'd be better off getting more focused information, that didn't have to all come at the same time. … Asking for more information is actually asking for less, more focused information." While as a whole, board members had difficulty articulating the sort of outcomes that would qualify as markers of success, a common theme was appreciation of hearing about the impact of program services on clients, whether through data from quality of life surveys or anecdotal stories about individuals. This idea is illustrated by one member stating "I really value stories. For the agency, telling a story would be great- and we have this notion that, 'even if we only help one person it would be worth it', so even one story would be great. They can highlight things that quantitative data can't necessarily get."

Board members commonly expressed the desire to understand how CCMHB funding fits in each program's broader funding context. For example, one board member explained "I think it's important to know the percentage of [a program's] funding that comes from our boards." Relatedly, board members are interested in knowing where else programs are applying for (and receiving) funding, because as one interviewee explains "Many programs assume that this is a permanent part of their budget, so they may not be very motivated to seek out other funds, which is becoming difficult given the amount of funding requests we have and funding that is available."

In addition to wanting to understand more about the success and impact of individual programs, multiple board members also expressed a desire to know more about the CCMHB funding as a whole, in the context of CCMHB priorities and broader community needs. For example, many want to know how much their funding decisions remain the same year after year, and how much money is left over for newer types of interventions. One board member explained "I'm interested in knowing how much of the funding is recursive and never really changing, versus flexible and available for new challenges and new needs. I've suggested that we summarize the funding under our priorities, like what we are funding here fits priority 1 and priority 2, to get a holistic [idea of if we] are doing our job)."

Some board members see evaluation of individual programs as helpful to them in making decisions how to shape their broader funding portfolio. For example, one interviewee noted "Because of upcoming funding decisions and increasing priorities, it would be nice to know that [for example] we have to keep this specific type of service up or there will be negative outcomes [in the community]; also [it would help us] say that we've funded a program long enough that we have flexibility to try new priorities, [if] they aren't 'make

or break' programs. [Right now] it's almost like when a new idea comes in, we have to say 'okay what do we have to stop to be able to do this'. [I'd like to] use data we have on current programs to see where there is flexibility to fund new programs."

Board members generally expressed a desire to avoid "high stakes evaluation." One particularly salient stance conveyed during interviews is a desire to use general evaluation results to make funding decisions, but with support and adaptive feedback built in rather than with a mentality of 'If you don't meet this outcome we will pull your funding'. As one board member articulates, "It's not that they report outcome information and okay they're out. For some agencies and programs when we want to encourage innovation, they're not going to be successful, but you don't just jump in and jump out right away." A second interviewee elaborates on this climate of support, expressing "Our intention in evaluation is to provide feedback, it's sort of like a thermostat. It's a system, and sometimes a system has to self-correct. If the programs aren't accomplishing goals, we want to give feedback for modification, not immediately take away resources." There was awareness that many programs could benefit from assistance in designing their self-evaluations. A board member expressed concern for "… [understanding] how should we help people evaluate, [how do we] build a skill set around evaluation?"

Generally, board members conceptualize their role as both grantmakers and supporters of agency evaluation. One interviewee elaborates on this viewpoint, explaining " [We should be] helping making decisions, giving people the evaluation tools to make decisions, and tools to do the job most effectively. We also need to realize parameters; you can't have data on everything, but if you have some piece of information, [then] how can you [create] some measurable outcomes for xyz? [The board also has to] recognize feasibility and that many agencies simply can't do the sorts of things I would like to do."

Part III

Recommendations and Proposed Plans for Implementation in Year 2

The following detail recommendations to pursue in the coming fiscal year (17/18). Each of these recommendations follows from information gathered from Board members and funded program representatives and is informed by the literature on building evaluation capacity. While these recommendations are presented individually, many are interconnected and would work in tandem when implemented.

1. Create a Learning Organization among Funded Agencies and the CCMHB

There is a tension concerning how tightly to yoke funding decisions to evaluation outcomes. On the one hand, some suggest that evaluation must be linked to funding decisions to create accountability. For example, Willoughby and Melkers (2000) found "the impact of funder mandates greatly diminished when staff did not believe that the measures would affect funding decisions." On the other hand, if the goal is to encourage

the use of evaluation data to improve client outcomes, a growth orientation that tolerates and creates space for formative evaluation processes which take place before or during program implementation with the aim of improving program design and performance is fruitful. Using data leads to valuing data; teaching and encouraging the use of data is a critical part of building capacity and creating a culture in which evaluation is not feared, but viewed as a fundamental part of intervention both by funders and grantees (Cousins and Bourgeois, 2014; Fetterman & Wandersman, 2005). If evaluation skills and efforts are not appreciated within the individual organizations and more broadly in the network of programs, it is likely that employees will not 'waste time' caring about or developing these skills (Newcomer, 2004). We recommend that the emphasis not be on narrow determinations of effectiveness, but on reflection and growth that is supported by data driven processes.

Primary evaluation strategies need to be designated as the mode of inquiry (e.g. formative vs. summative; Mark, Henry, & Julnes, 2000). Given limited resources to establish effectiveness, choosing a formative focus – or one that focuses on how services are provided and experienced – may be more realistic and sustainable. This would not ignore client outcomes, but would not create an expectation that feasible evaluation designs (e.g., lacking adequate comparison groups, random assignment, etc.) are robust enough to make firm conclusions about whether or not a given program is effective. To the extent to which programs are choosing evidence-based practices, the local evaluation focus can be on the extent to which they are implementing those practices with fidelity (i.e., as intended to achieve desired outcomes) and whether those served show similar perceived outcomes to those in studies that established the evidence-based practice. On the other hand, to the extent to which programs are implementing evidence-based practices that are significantly modified or tailored to the specific community or agency context, or are implementing innovative home-grown practices, local evaluation can focus on carefully documenting "practice-based evidence" of impact. The goal is to support the CCMHB and its funded programs to develop into a learning organization.

2. Create a Uniform Performance Outcome Format

It is difficult to consume large amounts of evaluation information. Using a wide variety of formats in performance outcome reporting makes this more difficult and results in inconsistent reporting from program to program. In addition, funders' reporting expectations should specify the information they want at a minimum (i.e., from every agency) so that judgments can be made about the strength of the claims regarding evaluation. Providing a report format or template that includes highly accessible and clear language may facilitate more comprehensive and clear reporting (Kelly, LaRose, & Scharff, 2014). Further, "an unambiguous, shared vision of success on the front end, before the grant is made, enables everyone—foundation, grantee, and evaluator—to know what the goals are, how they will be achieved, and how effectiveness will be judged" (Holley & Carr, 2014)

This could include editing language in the current grant application to add more specificity and/or offering an articulated framework and format for performance outcome

reporting (building on what is already done in Part II of the application, Utilization Statistics).

For example, performance outcome reports could be required to address the following. This would result in greater uniformity and less missing information.

a. A brief statement of the nature of the intervention (what did they aim to do?), program goals and expected shorter- and longer-term goals.
b. Access Statistics
    a. How many referrals were received?
    b. How many clients were effectively engaged in service delivery?
    c. How was engagement defined? (e.g., attended two group sessions)
c. Utilization Statistics
    a. How many clients were served?
    b. How many service delivery units were provided (e.g., using whatever the correct unit of measurement is)
d. Demographic Data on Clients Served
    a. Race/Ethnicity
    b. SES
    c. Zip Code
e. Methods
    a. Sample
        i. Sample size (from how many people is data reported)
        ii. Of those served, what % were reached for follow-up?
    b. Measures
        i. How was information gathered?
            1. From whom (e.g., clients, caregivers)
            2. By whom (e.g., supervisors, front-line staff, external evaluators)
            3. In what format (e.g., paper survey, online, phone interview, in-person)
        ii. What tools were used to gather information?
        iii. When was information gathered?
        iv. How often was information gathered?
f. Results
    a. What was learned from the measures used?
        i. Means (and Standard Deviations if possible)
        ii. Change Over Time (if assessments occurred at multiple points)
        iii. Benchmarks given shorter- and longer-term goals articulated
        iv. Comparison of strategies (e.g., recruitment, retention, treatment, intervention)
g. Implications
    a. In what ways was the evaluation used to support changes in practice? What changes were made based on evaluation findings?
h. Narrative Example(s)
    a. Describe a composite service delivery example to illustrate the work

3. Encourage and Support the Development of Theory of Change Logic Models

Theory of change logic models require the articulation of goals (i.e., desired outcomes) and various intervention facets related to achieving those outcomes. Theories of change are beliefs about what program participants need and what strategies will enable them to meet those needs. Program logic models are tools for expressing these ideas and serve as operational plans linking activities to expected outcomes. In the context of known CCMHB funding priorities, logic models might also help programs connect their own program goals to these priorities. Used properly, evaluation activities flow directly from logic models (Kelly, LaRose, & Scharff, 2014). The CCMHB might consider workshops in which agencies are supported to create theory of change logic models for their own programs. This could provide a foundation for evaluation (process and outcome) and also locate the effort of an agency funded by the CCMHB in the broader context of funded agencies' programming. Further, building evaluation plans that are congruent with individual program's goals, not solely for compliance or funding purposes, increases trust and buy-in to evaluation mandates (Rorrer, 2016).

4. Create or Use Existing Settings for Organizations to Share Lessons Learned from Evaluation

If evaluation data are gathered, it is essential that they be used. These are different facets of capacity – one is focused on *doing* evaluation and the other on *using* evaluation. Creating forums in which funded agencies share what they are learning may facilitate use and also cross-agency support and learning. The MHAC meeting appears to be used largely for reporting out on other meetings (e.g., those of the CCMHB and CCDDB) and for agency announcements. While this serves a useful purpose, this is a space in which major leaders are together and could be used for substantive exploration of what is working and *not* working in their current service delivery efforts (a critical part of fostering a learning organization).

5. Consider Two-Year Contracts to Encourage Innovation and Evaluation

One of the challenges in the use of evaluation is that it takes time to implement and see results. It is likely that agencies would be pursuing funding for the following year *before* they have learned anything from their current year of implementation. In instances in which people are actively engaged in a new, innovative, evidence-based or highly desired effort (i.e., in strong alignment with CCMHB priorities) two year funding might facilitate more deliberate data driven practices. These contracts could be reserved for high priority areas for the Board and/or when programs are engaged in considerable innovation. Two-year contracts would require an evaluation plan with a logic model (see #3) that clearly indicated what data would be gathered and how it would be used.

6. Choose Four Programs for Targeted Evaluation Support

It is not realistic to develop tailored evaluations for all funded programs, but there is the potential to provide support to four agencies to enable them to implement their own evaluations. These agencies should be chosen to reflect some of the diversity in funded programs. For example, one might be a larger program focused on mental health or substance use; another might be a smaller organization focused on community-based services with youth; a third might be a trauma-focused organization. In any case, elements of the evaluations and tools created in these sites can later be transferred to other funded agencies in subsequent years.

7. Create an Evaluation Consultation Bank

Given the diversity of programs funded by the CCMHB, standard or uniform measures are probably not viable or desirable. However, support in the creation of more credible evaluation that is tailored to the diversity of programs could result in higher quality programming. Many organizations do not incorporate evaluation because they lack resources and expertise. Providing a mechanism for technical assistance increases evaluation capacity (Kelly, LaRose, & Scharff, 2014) and offers the opportunity to create sustainable evaluation plans that programs can maintain on their own following the initial individualized investment (Kirsh, Krupa, Horgan, Kelly, & Carr, 2005). The Bank could operate alongside the focused efforts in the four organizations chosen for intensive support. Agencies accessing the Bank could get targeted support to develop specific facets of their intervention efforts.

8. Build a "Buffet" of Tools

As funded agencies develop tools (or are supported in the development of tools) they can be housed in a shared space (this may be limited for proprietary measures that cost money to administer). A Google Drive or other web-based resource could be used to share information. This could include, for example:

a. Assessment/Instrument Repository
    i. Instruments/Tools/Surveys could be shared for use across entities.
    ii. Free measures from credible sources (e.g., the NIH) could be highlighted.
b. Excel spreadsheets that can be used to provide data summaries and generate figures based on data entered
    i. Excel allows for the creation of basic templates that will turn data into figures. These could be created for funded agencies to support reporting performance outcomes in consistent ways.

9. Encourage Cross-Agency Evaluation Mentorship and Apprenticeship

There are champions for evaluation and those with more experience who work within given funded agencies. Creating a structure in which those with more experience can mentor those with less experience can expand evaluation resources. For example,

agencies that receive tailored attention to develop an evaluation can commit to providing mentorship in the following year to an organization that will adopt a similar process. Funded agency representatives expressed interest in this type of opportunity and a desire to receive such mentorship. This may also contribute to a *culture* of evaluation practice as desired and normative and a learning organization among funded agencies and the CCMHB.

10. Identify Priorities at the Community-Level and Pursue those Questions

The CCMHB could choose questions that are about the system as a whole and pursue those. This is a form of self-evaluation at the level of the Board and may serve to clarify priorities for subsequent years and to increase communication / coordination with other funders. These could include questions related to: a) Cross-Agency Coordination (e.g., how often do funded agencies partner in the service delivery process?) and Cross-Agency Access to Services (e.g., which clients are most likely to be served by CCMHB funded agencies?).

Attachment A

A Proposal to Build Evaluation Capacity for Programs
Funded by the Champaign County Community Mental Health Board (CCMHB)

Statement of Purpose:
The aim of this effort is to build evaluation capacity for programs funded by the CCMHB. Evaluation capacity refers to both formative (i.e., questions about process) and summative (i.e., questions about outcomes) facets of program evaluation.

Specific Aims:
To move toward this goal, we propose the following specific aims:

1. Identify evaluation priorities for the CCMBH
2. Identify evaluation priorities for funded agencies
3. Explore current reporting and/or evaluation mandates from a variety of funders (e.g., CCMHB, United Way, DHS)
4. Build scientific/evaluation literacy among key stakeholders (e.g., CCMHB, funded programs)
5. Explore existing capacity for data collection and analysis (i.e., looking at processes and outcomes)
6. Assess the potential (and limitations) of rigorous outcome evaluation (e.g., explore the possibility of random assignment, control groups, waitlist control groups) and process evaluation across funded programs
7. Assess the potential for shared outcome or process assessment across funded programs or subsets of programs
8. Build capacity for data collection and analysis in targeted programs in Year 2 (i.e., looking at processes and outcomes)
9. Plan the implementation of evaluation activities in Year 2 (e.g., instrument development, data collection, data analysis, interpretation and reporting)

Proposed Activities and Deliverables (Year 1)
To advance these aims, we propose the following activities in Year 1 of the effort:

1. Review all agency funding applications (Parts 1 – 3) and consumer outcome and utilization data to
   a. begin to assess numbers of clients served, nature of service delivery, relevant outcomes, relevant processes
   b. examine how current funded activities align with stated priorities and goals.
2. With a small number of targeted agencies begin to explore a) evaluation priorities among funded agencies; b) existing evaluation capacity and activities; and c) issues in the process of building evaluation capacity (e.g., unfunded mandates; costs to program in terms of times and resources); d) potential best practices in how evaluation would be sustained (e.g., via agency self-evaluation; CCMHB staff; external evaluator)

3. Conduct interviews with leaders, staff and/or clients from each funded agency to explore evaluation priorities, capacity and activities
4. With input from targeted agencies and the CCMHB, develop a survey of funded programs to be required in the 16/17 fiscal year that assesses evaluation priorities, capacity and activities
5. With input from funded agencies, clients, and the CCMHB, develop an initial plan to implement evaluation activities in a subset of funded agencies (specifics to be determined by engaging in the exploration process)

Deliverables

1. A report to CCMHB that summarizes findings from 1 and 3 in Activities and includes specific recommendations regarding building evaluation capacity
2. A survey to utilize in anticipation of the 16/17 funding year that assesses evaluation priorities, capacity and activities with all CCMHB funded agencies
3. An evaluation plan to implement in Year 2 that reflects priorities and recommendations developed in Year 1. Most likely this would begin with a targeted subset of agencies, but the data gathered in Year 1 would inform the specifics of the evaluation plan developed.