
The Fort Bragg Evaluation

A Snapshot in Time

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The recently completed Child and Adolescent Mental Health Demonstration Project¹ at Fort Bragg, North Carolina, has provided an opportunity to develop a fully comprehensive continuum of mental health and substance abuse services and thus make available to the population a wide range of readily accessible treatment options. When the demonstration project began in August 1989, a comprehensive evaluation was also included to study the implementation process, the quality of the system, and the impact of the comprehensive system on treatment outcomes and costs of services. The evaluation was carefully designed and rigorously executed, representing a major contribution to understanding the complexities of field-based studies with multiple sites, large volumes of data to be collected, and a large number of participants to be followed.

The evaluation findings have raised many questions. Some of the most relevant questions address the usefulness of the continuum of care and the effectiveness of changing the structure of service delivery on clinical practice and outcomes. However, postevaluation information (Heflinger & Northrup, 1997; Pires, 1997) provides some insights into both of these areas and also offers insights into some of the potential pitfalls in the evaluation of complex programs.

In the original plan, careful consideration was given to the timing of the evaluation, recognizing that time was needed to develop the continuum of services and allow them to become stable before beginning to collect data. Consideration was also given to providing the longest period possible for data collection and allowing sufficient time for data analysis. The contracting agency, the U.S. Department of the Army, insisted that a final report be issued before the end of the demonstration project, scheduled for May 1994, with the final report due in September 1993. Thus, data collection began in January 1991, six months after service delivery began, and concluded in May 1993. Seemingly, this careful timing of the evaluation should have led to a snapshot in time, at the most optimal time. However, having concluded the data collection as scheduled in May 1993 and having continued the service component of the project until September 1995, postevaluation information now has raised the question of the adequacy of the snapshot in time to provide a complete picture of the impact of this project, especially

for the outcome and cost studies (Heflinger & Northrup, 1997; Pires, 1997). In other words, there is little question that the evaluation was done well, but there is some question about whether the evaluation was really done at the right time to support the conclusions provided.

Lourie (1997) used the concept of "service maturation" to describe the state when the full range of services are in place and when they are fully operational. Using this concept, service maturation in the Fort Bragg Demonstration Project occurred late in 1993, that is, at the time when new service components were no longer added and the services were fully staffed and operating smoothly. The last service to be added was the crisis group home in January 1993; the Attention Deficit Disorder Clinic began in May 1992 but was not fully staffed until May 1993; psychiatric services began at half capacity in December 1991 and reached full staffing in August 1993; and the in-home services were fully staffed in February 1993. All of these services became fully functional just at the time when the last wave of data was being collected in January through May 1993. Beyond becoming fully functional, the issue of full efficiency in service delivery is more elusive, but certainly the program was not fully efficient before the last wave of data for the evaluation report was collected. Thus, the impact of these services, both on treatment outcomes and costs, was not part of the evaluation findings.

The issue of cost of services was addressed in the evaluation findings (Bickman et al., 1995), noting that

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services were more expensive at the demonstration site than at the comparison sites, primarily because more service per client was provided—more being either more services in combination or a longer length of service. The original intent of the demonstration was to determine whether the availability of a full range of service options would reduce the use of more costly, less appropriate care and thereby reduce the cost of services per client. However, this intent was compromised by the Army's concern that services not be restricted or limited in any way, so as not to compromise the CHAMPUS benefit; thus, for the first two years of the project, the message to program staff was quite mixed. A second part of the original intent of the demonstration project was to determine "the true costs of services" not compromised by the lack of service options or by cost-containment mechanisms. This approach to service delivery can hardly be called "managed care." Although it is tempting to apply the evaluation findings to current events, the evaluator as purist must be careful not to redefine the study and the findings to proclaim knowledge for the sake of proclaiming knowledge, especially on a topic, such as managed care, for which people on all sides of the issue are seeking simple answers.

The data gathered postevaluation, between May 1993 and September 1995, on program costs are most interesting. During this time period, the following occurred: the continuum attained the state of "service maturation"; the staff understood the evaluation findings to mean that the quality and impact of treatment might not be compromised by shorter length of service and less multiple services at the same time; the contract requirements were lessened through negotiation with the Army, which sought to extend the contract beyond the demonstration period; and an incentive payment was offered by the Army relative to the amount the program costs could be reduced.

These four factors contributed significantly to cost reduction, based on the implementation of cost-containment strategies using managed care concepts while retaining quality services and not denying access to service. Langmeyer (1997) reported the following: During a three-month period in 1994, there was a 44% increase in the number of admissions to the program; in 1994, the cost per client served, calculated as billable charges, was 59% less than the billable charges in 1992; in 1992, 6% of the clients received services valued in excess of \$25,000, accounting for 63% of the billable charges, whereas in 1994, less than 2% of the clients received services valued in excess of \$25,000, accounting for 28% of the total billable charges; and the overall program budget was 24% less, reduced from \$19,000,000 to \$14,500,000 (rounded). Heflinger and Northrup (1997) clarified the impact of these substantial reductions in cost as not compromising clinical care.

The above discussion is not intended in any way to reflect negatively on the evaluation findings. They are what they are. However, the above comments are intended

to raise cautions to the prudent evaluator about the risks of drawing sweeping conclusions from a study done at a point in time—thus, the reasons for replication studies and ongoing evaluations of complex programs.

Another important contribution of any well-done evaluation is the issues it uncovers that can serve as the questions for future study. The evaluation (Bickman et al., 1995) of the Fort Bragg Demonstration Project has generated several significant questions with implications for health care funding in the future. First, there were a substantial number of children, twice as many as in the comparison sites, who sought mental health and substance abuse treatment at the demonstration site. Because of this high percentage (9%–13%, depending on the year) of the eligible population who sought treatment, several levels of review were instituted to verify that these clients legitimately needed mental health or substance abuse treatment; each review substantiated that those receiving services were genuinely in need of treatment. Furthermore, there is no reason to believe that the population at Fort Bragg differed from the populations at the comparison sites. Friedman, Katz-Leavy, Manderscheid, and Sondheimer (1996) reported a recommended national prevalence rate of serious mental health problems for children and adolescents to be 9%–13%, which is consonant with the utilization rate at the demonstration site, suggesting that utilization closely paralleled prevalence at the demonstration site.

Thus, a set of unanswered questions relates to the costs and outcomes, in the comparison sites or in other sites, for those in need of services who do not receive them. Do they receive services from pediatricians or family practitioners; do they receive services through schools, the child welfare system, the juvenile justice system, or state-funded institutions; or do they receive no services at all? Additional questions are (a) what is the cost of these services and (b) what is the ultimate cost to society of inappropriate services or no service?

A second set of unanswered questions relates to the definition of mental health care, who should provide it, and who should pay for it. Pires (1997) and Lourie (1997) noted that in the Fort Bragg site, other agencies tended to redefine problems that they formerly addressed as mental health problems to be treated in the demonstration project. As stated above, these problems justify mental health diagnoses but nonetheless may be typically treated in other settings, by schools, child welfare agencies, and others discussed above. Given that the Fort Bragg Demonstration Project has provided some understanding of the prevalence of mental health and substance abuse problems and, using 1995 data, some understanding of the cost of services, additional work now should be done to address these important public policy issues.

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