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BUILDING INTERORGANIZATIONAL LINKAGES: A TEST OF AN ORGANIZATION DEVELOPMENT MODEL

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BUILDING INTERORGANIZATIONAL LINKAGES:

A TEST OF AN ORGANIZATION

DEVELOPMENT MODEL

By

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ABSTRACT

BUILDING INTERORGANIZATIONAL LINKAGES: A TEST OF AN ORGANIZATION DEVELOPMENT MODEL

By

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The increased attention to the structure, function, and development of complex organizations stands in contrast to the scarcity of literature on interorganizational interaction. In fact, a review of the literature revealed a lack of focus on mechanisms for actually creating or altering the level of interagency cooperation. There were, however, several key concepts in interorganizational relations which seemed applicable to any attempt to influence interaction; most relevant among these were resource interdependence, goal and task similarity, and interagency awareness.

In addition, several strategies from the field of organization development (OD) were addressed to relations among separate groups. These strategies, including "team building" and the "family group diagnostic meeting," were combined with the concepts of interorganizational theory to create an intervention strategy designed to create interagency linkages. It was hypothesized that an ODoriented workshop would increase perceptions of similarity in goals and tasks between representatives from different agencies, which would, in turn, lead to greater interorganizational interaction.

Community mental health centers (CMHC's) and nursing homes were addressed as the focus of this study as two types of organizations which could mutually benefit from increased interactions. Twenty-two mental health centers (CMHC's) were solicited from HEW Region V to take part in a one-day workshop. Each CMHC secured the participation of representatives from four to six nursing homes from its catchment area.

Mental health center-nursing home groups were randomly assigned to one of two workshop treatment conditions. The first, a "traditional" workshop, presented the rationale and methods for cooperative programming in a didactic, practically oriented manner. The second, an "organization development (O.D.)" workshop, utilized O.D. exercises to examine each organization's goals and services. Practical programming material was provided to this group in the form of two shortened lectures, as well as through a manual presented to all participants.

Questionnaires administered to each participant two weeks before the workshop, immediately following the workshop, and at a 10-week follow-up were designed to

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assess the participants' perceptions of similarity of goals and services as well as their degree of interaction with the other organizations. In addition, a designated contact person from each CMHC was interviewed at length at 4-week and 10-week intervals after the workshop for more outcome data.

Results indicated that the O.D.-oriented workshop was indeed able to alter the CMHC staff's perception of goal and service similarity with nursing homes; at both post-workshop and 10-week measurement periods, those CMHC staff in the O.D. condition felt a greater similarity with nursing homes than those from the traditional workshop.

However, this perceived similarity among organizations did not correspond with a significant differential increase in interaction, visits, or joint programming for the O.D. workshop condition. There were no differences between the two conditions in subsequent interaction, with both revealing a substantial increase.

Discussion focused on the fact that the O.D. techniques were indeed capable of having their intended effect but called into question any special utility of these effects in fostering interorganizational interaction. In addition, it remains questionable whether the concepts of goals and task similarity form a valid rubric for assessing interorganizational interaction. Suggestions for further examination were also presented.

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CHAPTER I

INTRODUCTION

Critical Concepts in Interorganizational Relations

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The increased attention to the structure, function, and development of complex organizations stands in contrast to the scarcity of literature on interorganizational interaction and cooperation (Litwak & Hylton, 1962). As Evan (1971) has noted, "the relative neglect of interorganizational relations is all the more surprising in view of the fact that all formal organizations are embedded in an environment of other organizations" (p. 175). Early works of Litwak and Hylton (1962), Thompson (1967), and Lawrence and Lorsch (1969) were among the first to view the organization as operating in an environment of other organizations. These authors, however, tended to concentrate largely on the effects of this environment on the target organization and ignored the interorganizational relations in this environment.

However, several authors have argued for a more comprehensive examination of interorganizational relations. Black and Kaase (1963) cite several reasons that

interagency cooperation has been forced upon our attention, especially in the medical and human services area. Among these, the foremost are the drastic growth in our population and shifts in age distribution, which at once deplete resources in traditional service areas and increase problems in newer areas, such as the treatment of chronic conditions among the elderly; the changing technology of medical care; and the increasing overlap of medical and social service agencies, especially in the recognition of psychological components of illness and of family-centered care. Levine and White (1963), in a further assessment of coordination among health and welfare agencies, decry the lack of systematic attention to this problem, but maintain that

. . . while there is little empirical evidence that interagency cooperation per se is necessarily related to organizational effectiveness, there is good reason to believe--for various direct service agencies at least--that some organizational objectives would be furthered by greater cooperation with other agencies. (p. 341)

A comprehensive review of the literature on interorganizational relations, including the work of Levine and White (1971), Evan (1966), and others, reveals few systematic empirical tests of theoretical viewpoints; further, no methods of promoting interagency cooperation have been attempted and critically evaluated. However, several authors have begun to advance certain factors which are of value in an analysis of what Warren (1970) refers to as the "interorganizational field."

Exchange as a framework. (One of the more comprehensive views of interorganizational relations is that of "organizational exchange," as proposed by Levine and White (1961). According to these authors, [organizational exchange "is any volunteer activity between two organizations which has consequences, actual and anticipated, for the realization of their respective goals or objectives" (p. 588). Because of what the authors cite as a constant scarcity of resources, especially in the health care field, Organizations can more easily approach their goals through a realization of their dependency for some of these resources on other agencies. \ Exchange may take place in three categories: (1) referrals of cases; (2) exchange of labor services; and (3) exchange of nonlabor resources, such as funds, equipment, and information (Levine & White, 1961). In addition, Levine and White (1961) cite a typology of five increasing levels of interagency relationships, as created by Johns and de Marche (1951), around the following dimensions:

- Those involving further acquaintance with other agency leaders;
- 2. Those resulting in the exchange of information;
- 3. Those which, in addition to furthering acquaintance and exchanging information, have resulted in specific consultation representatives to other agencies;
- Those which, in addition to those above, have resulted in definite planning with representatives of other agencies;
- 5. Those which have resulted in definite operating responsibilities with representatives of other agencies. (p. 340)

Thus, organizational exchange, whether in terms of human or nonhuman resources, varies along this scale which seems to imply a differing level of commitment. The first case, merely becoming more acquainted with other agencies, is a benign and nonthreatening activity, while the fifth, sharing operating responsibilities, requires a surrender of some degree of autonomy and authority on the part of each organization. This final level of coordination is often not attempted because of the threat it holds for organizations and because of the easier success at earlier levels. For, as Levine, White, and Paul (1969) maintain,

Because ideas of coordination and cooperation are embedded in powerful social values, clear understanding and objective studies of interagency cooperation are rendered difficult. Who, for example, would admit opposing cooperation when the welfare of a patient might be involved? (p. 166)

Resource interdependence. To many this seems to be the major factor influencing interorganizational cooperation or coordination. As noted above, Levine and White (1961) view the exchange of resources as the definition of interagency interaction. Reid (1969) defines resources as "the instruments an organization employs to achieve its goals" (p. 177). If these resources are scarce, or unevenly distributed, the organization must look outside of itself if it is to reach its objectives. In health and human services agencies, the most common resources exchanged fall into three categories:

(1) clients; (2) consultation personnel and skills; and (3) information, especially concerning cases (Levine, White, & Paul, 1969). Thus, even though an organization recognizes its scarcity of resources and thereby limits its functions (e.g., the Red Cross does not do heart surgery), "it can seldom carry out even these functions without, to some extent at least, cooperating and establishing relationships with other agencies in the health and welfare world" (Levine et al., 1969, p. 165).

Lehman (1975) in analyzing this exchange of resources proceeds one step further than Levine and his colleagues by expressing the importance of both the significance of these resources and the symmetry of the exchange. By "significance," Lehman is concerned with the degree of importance that exchanged resources have for the primary goal realization of an organization. For example, a rural health clinic may not be able to exist without the exchanged services of a physician one day per week; thus, for this organization, the resource is what Lehman calls a "primary or goal-related resource." A Visiting Nurses group which occasionally receives the donated services of a psychologist from a university is definitely enhancing its goal pursuit through this exchange but would not cease to exist were this exchange discontinued.

The concept of symmetry as proposed by Lehman (1975) is even more crucial in understanding resource exchange. As Lehman states,

It seems important to determine not only what kinds and how many resources the units are sharing or exchanging, but also whether one organization is exclusively a supplier and another a recipient, or whether there is in fact some authentic reciprocity inherent in the relationship. (p. 11)

In the case of a rural health clinic receiving a doctor from an urban hospital, the reciprocity is questionable; however, if because of Federal regulations the hospital had to offer services such as this, a stronger case for reciprocity may be argued, even though the hospital is not receiving any resources per se. Nevertheless, this example points out one of the weaknesses in a nonreciprocal exchange: the relative lack of power of one party gives it little leverage. The hospital could still meet its requirements by providing the physician to another agency, with little or no damage to itself but with fatal damage to the first rural clinic. As Benson (1975) notes,

. . . each party must hold something of value for the other party and be capable to resisting the other's demands. This does not mean that equality is a precondition . . . on the contrary, exchange between unequals is common. The important consideration is that neither party be powerless in relation to others. (p. 241)

Domain consensus. According to Levine and White (1961), the domain of an organization consists of "the specific goals it wishes to pursue and the functions it

undertakes to implement its goals" (p. 597). For example, the domain of a health care organization is the disease covered, the population served, and the methods used to serve this population with this disease. This concept is crucial to interorganizational cooperation because any agency must feel that the other agencies are operating in their proper domain before it will enter into any sort of exchange relationship. If the local Cancer Society works only with adults and has no need to expand, it would be more inclined to lend its materials to another agency for education of children. This concept of domain consensus is the organizational counterpart of what Sarason (1972) calls "professional preciousness," the staking out of a certain territory and quarding it against the incursion of outsiders. Thus, Levine and White (1961) feel that domain consensus is a prerequisite for interorganizational exchange or cooperation.

Further analysis of the work of Levine and White reveals the implied qualification that domain consensus is of most relevance in a state of limited resources or of conflict between organizations. Thus, agencies that must rely on public fund raising are very conscious of the fund-raising domains of other agencies, because of the limited amount of total funds available; however, two mental health centers, each supposedly serving a

separate catchment area, will not worry about crosscatchment referral of clients as long as clients abound and waiting lists remain long.

Interagency awareness. At the simplest level, Levine, White, and Paul (1969) have hypothesized that there can be no exchange or interaction between agencies which are unaware of each others' existence or functions. In a study in one community, they found this lack of awareness to be astounding: data concerning interagency awareness about services among 34 agencies was tabulated in a 34 x 33 matrix; more than 50% of the cells were filled in by "don't know" (Levine, White, & Paul, 1969). It was, therefore, not surprising that there was almost no interaction among these potentially interrelated agencies.

Reid (1969) has noted that often the degree and type of communication between members of different organizations may serve as a base for later coordination by increasing the awareness of possible interdependence or need for exchange. This communication may arise from similarities of staff professionally (Barth, 1963), from interaction among decision-makers (Morris, 1962), or from the intervention of a third, or coordinating, agency (Litwak & Hylton, 1962). Reid (1969) cautions, however, that if there is no need for exchange (e.g.,

resource demands), or no domain consensus, interagency coordination will not occur no matter how powerful the communication.

Related to this issue of communication between organizations is the concept of "boundary personnel" as proposed by Thompson (1962) and Evan (1971). Although not studied empirically, this viewpoint tends to hold that much of interorganizational interaction can be explained by an analysis of those persons who are charged with the "foreign affairs" of the organization, e.g., the public relations director of a hospital, the consultation-education director of a community mental health center. According to this viewpoint, these personnel are subjected to differing pressures in their roles from both internal and external forces; and it is their individual response, or role-set, that defines the interagency activity of the organization (Evan, 1971). Unfortunately, this viewpoint tends to ignore the concepts of resource dependency and domain consensus, and shifts the unit of analysis from the organization back to the individual.

Litwak and Hylton (1962) have combined the concepts of interdependence in resources and of interagency awareness with the dimension of task uniformity-nonuniformity into a series of hypotheses concerning the level of interorganizational relations. The most relevant

implications of their theory are that under situations of moderate interdependency (the norm), high awareness tends to lead to more coordination, and high standardization leads to more formalized coordination. Thus, to analyze the potentials for interaction and the most efficient forms of coordination in any community, the authors suggest that it is crucial to observe the agencies' awareness of their interdependency and their degree of standardization in output tasks.

Conflict. Litwak and Hylton (1962) originally postulated three modes of coexistence among organizations: independence, interdependence, and conflict. Independence can only occur when two organizations have no need for resource exchange, have complete consensus on domain, or are entirely unaware of each other. Interdependence implies a need for each other's resources, in some way or another, for goal attainment, and is the state heretofore discussed in considering interagency cooperation. Conflict, the third state of coexistence, is the most problematic for interorganizational interaction. As discussed above, conflict usually occurs with unresolved domain consensus; however, conflict can be a state which leads to greater interaction among agencies in certain situations.

Litwak and Hylton (1962) see a state of partial conflict as the underlying assumption of

interorganizational relations and analyze these relations as a form of interaction under such conditions. Total elimination of conflict concerning goals and domains leads to a breakdown of interagency autonomy and either a literal or practical merger. Reid (1969) sees conflict as highly related to interdependence; in fact, these states are easily interchangeable with minor shifts in goals and resources. In Reid's view, conflict over resource inputs is the typical competitive situation and is usually resolved by coordination; for example, a United Fund drive. Conflicts over exchange, i.e., how to work together, only take place in an already interacting situation; these are usually resolved by bargaining and compromise, while still maintaining each agency's autonomy. Conflict over the output of resources, or the legitimacy of an agency's function, are usually hardest to resolve because of the implied fundamental disagreement in domain consensus. However, the first two types of conflict mentioned, over resources and exchange, are often quite satisfactorily resolved because of the recognized state of interdependency; thus, conflict must not always be viewed as antithetical to interagency interaction (Reid, 1969).

<u>Goal and task similarity</u>. Some of the earlier writings on interorganizational relations made preliminary mention of goal similarity and/or task similarity as being

either prerequisites or indicators for interaction. Evan (1971) hypothesized that "the greater the degree of similarity of goals and functions between the organization set and the focal organization, the greater the amount of competition between them and hence the lower the degree of decision-making autonomy of the focal organization" In other words, goal and function similarity (p. 182). correspond to a lessened independence of organizations, which leads to a heightened propensity for interaction because of interdependence or partial conflict (Litwak & Hylton, 1962). Evan (1971) also hypothesized that "the greater the complementarity of functions between the focal organization and the members of its set, the greater the likelihood of cooperative action" (p. 183). Thus, tasks must not necessarily be similar but must at least be complementary, or related in some meaningful way.

Form and Nosow (1958) studied the increased organizational interdependence and cooperation during community crises; they hypothesized that the outbreak of a crisis tended to lead to a convergence of organizational objectives, and thus a greater sharing of goals than existed before, and after, the crisis state.

A further elaboration on this issue of goal similarity was provided by Reid (1969), who initially hypothesized that organizations interact when they perceive that they are interdependent; i.e., that their respective

goals can be met most effectively with the assistance of the other. As Reid notes, these goals need not be identical or even similar; however,

. . . similarity of goals, though not strictly necessary, promotes additional cohesion between the organizations and leads to more stable exchanges. To the extent goals are similar, organizations can further their own goals through one another. Further, common goals facilitate communication and provide a basis for rational division of labor between organizations. (p. 179)

A more comprehensive empirical view of the relationship between interorganizational relations and perceived goal and task similarity is provided by Tornatzky and Lounsbury (1973). In a study of 27 public service agencies, the authors attempted to discern those inter- and intraorganizational factors which were related to interorganizational interaction. A cluster analysis (Tryon & Bailey, 1970) of 115 separate variables revealed that,

. . . perceived goal and task similarity and perceived beneficiality of collaboration are virtually at one correlationally with degree of interorganizational interaction. Thus, it would be possible based on these data to predict the gross amount of interorganizational interaction of a given organization based on the extent to which it "sees" itself and is "seen" as being similar in goals and tasks to other organizations. (p. 10)

Furthermore, the authors found no intraorganizational variables which related significantly to interorganizational interaction.

Changing Interorganizational Relations

While the literature on interorganizational interaction is spotty at best, the literature on changing or influencing interorganizational relations is almost nonexistent, especially if one is interested in empirical or experimental studies. Levine, White, and Paul (1969), who have been among the forerunners in theorizing upon the interorganizational field, provide only a few suggestions to achieve interagency cooperation: (1) turn to the national or state level if the local level fails; (2) improve the knowledge agencies have regarding one another; (3) educate board and community leaders to the virtues of cooperation; (4) provide professional incentive; and (5) establish formal responsibilities and mechanisms for cooperation.

Benson (1975) has gone somewhat further, explicating four strategies for changing the network of organizations: (1) cooperative strategies, through joint planning and contractual arrangements; (2) disruptive strategies; (3) manipulative strategies, applied from above by government bodies; and (4) authoritative strategies, when one party has sufficient power. Unfortunately, these strategies remain vague in their implementation and imply, except for the cooperative strategies, a strong community organization perspective with much power over the system or elements within.

Keith (1974) attempted to manipulate organizations' perceived similarity of a target organization to observe whether increased similarity would relate to increased attraction. Results were negligible, but the methodology was judged to be flawed, especially as Keith noted, in that the manipulation of perceived similarity may have been too diluted or not operating as expected.

A Theoretical Model for Promoting Interaction

Given the theoretical perspectives of Levine and White (1961), and Reid (1969) and the empirical findings of Tornatzky and Lounsbury (1973), it seems that the encouragement of interorganizational interaction must include some concern for the dimensions of goal and task similarity. This is especially true when dealing with organizations which should theoretically be interacting but have little or no knowledge of their potential interdependence (Levine, White, & Paul, 1969). The following study consists of an attempt to create interorganizational linkages between noninteracting organizations (community mental health centers and nursing homes) by use of a newly devised technique, Goal Congruency Training (GCT). This technique represents an operationalization of the goal/task similarity and interagency awareness dimensions into a specific interorganizational intervention strategy. For this purpose,

much of the specific activity has been drawn from some of the organization development and change literature, which should be looked at briefly here.

Organization development (OD) is a broad and amorphous field which proves extremely hard to define, but for the present it can be viewed as a series of interventions within an organization designed to increase the organization's effectiveness (Huse, 1975). At present, there is no OD body of literature concerned with <u>relations between</u> organizations; however, some of the OD work which addresses relations between separate groups <u>within</u> an organization sheds light on potential interagency methodology, specifically the OD technique known as "team building."

Team building. Johnson (1973) defines team building as "any planned event with a group of people, who have or may have common organization relationships and/or goals, which is designed to improve the way in which work gets done by them" (p. 2). As can be seen, this is a rather broad definition, especially as relates to outcome criteria, but the crucial elements are that it is a "planned event" with a "group" of people and may concern their relationships or goals. Teams can be categorized, according to Huse (1975) as follows: "(1) groups reporting to the same heirarchical supervisor; (2) groups involving people with common organizational

aims; (3) temporary groups formed to do a specific, but temporary task; and (4) groups consisting of people whose work roles are interdependent" (p. 230). Two specific team-building techniques are relevant here. One, generally called the "family group diagnostic meeting," consists of a meeting of any work group designed to analyze its function. Diagnostic data are collected either beforehand or at the meeting, and preliminary plans are formulated for any problems which surface. This technique focuses heavily on both interpersonal communications and task effectiveness (Huse, 1975). The "family group team building meeting" contrasts in that it is more specifically directed toward the group's goals and it is more action-oriented rather than stopping at the diagnosis and surfacing of problems. Huse (1975) has found that team building efforts tend to be more successful if the boss is supportive, if the team has some crisis or outside motivation for change, and if team members have great freedom to discuss a wide range of possibilities for change. Team building is especially effective for groups which have been pulled together on a temporary basis for a temporary task (Huse, 1975).

Intergroup relations. A highly related branch of OD techniques known as "intergroup relations," also sheds some light on the potential interorganizational intervention. The basic strategy for improving intergroup

relations, as reported by Huse (1975) is "to change the perceptions (perhaps, more accurately, misperceptions) that the two groups have of each other" (p. 240). One technique for improving intergroup relations, developed by Blake, Shepard, and Mouton and reported by French and Bell (1973), is designed specifically for situations wherein relations between two groups are strained or overtly hostile. Each group independently generates two lists: one giving their impressions of the other group and another predicting what the other group will say about them. The two groups then come together, present these lists without discussion, and separate again to generate a list of priority issues that still must be resolved between the two groups. Finally, the groups meet together again, combine lists, and generate plans for action. French and Bell (1973) report success using this technique in a one-night meeting between policemen and parole officers.

A similar technique developed by Fordyce and Weil and also reported by French and Bell (1973) differs in that each group builds three lists initially: a positive feedback list about the other group; a "bug" list containing gripes about the other group; and an "empathy" list predicting what the other group is saying. After coming back together again, the group builds a master list, or agenda for change, and proceeds to develop a

master plan. The advantage of this technique is that the groups do not separate again but plan any priority listing together; theoretically this prevents them from building up within-group hostility after the presentation of the other's gripe list.

The final intergroup relations strategy of relevance here is the "organization mirror." This is most useful in a situation where one focal organization, the "host" group, is desiring to straighten out its relationships with several other organizations. The technique uses what is termed a "fishbowl," wherein one group sits on the inside of a circle and listens to the other group(s) on the outside discuss their relationship. "Fishbowl" seats are reversed, after which the groups meet together to plan any action steps. This strategy applies especially when one coordinating or central agency has independent relations with several outside agencies (French & Bell, 1973).

<u>Goal Congruency Training (GCT</u>). As noted above, the strategy proposed for creating interorganizational interaction (Goal Congruency Training) derives from several of these OD techniques. The major objective of GCT is to increase interaction between organizations which "should be interacting according to the concepts of interagency relations presented above. It is hypothesized, after the work of Reid (1969) and Tornatzky and

Lounsbury (1973), that increasing the organizations' realization of their task and goal similarity (through intergroup relations techniques) will create a greater propensity for interaction. Linking this attempt at increased goal congruency with specific team building techniques designed to create an interaction plan (created by a newly developed team) will thus lead to greater interorganizational interaction. The team thus developed will maintain responsibility for management and monitoring of the interactions.

As can be seen, GCT is a more finely aimed version of OD techniques, directed between agencies rather than within and designed to create interaction rather than satisfaction, cooperation, or understanding. Nevertheless, some may argue that interaction per se is an extremely nonspecific goal, and in most cases this would be correct. However, it will be most helpful here to shift gears and look at the target agencies for this GCT effort in order to better understand the purposes of this research. Primarily, it is necessary to first examine the nursing home as a resource-weak agency, establishing the seriousness of its problems as a potential target of CMHC services, and finally present one case of CMHC-nursing home interaction as an example of benefits from this goal.

The Quality of Life in Nursing Homes: A Problem of Interorganizational Interaction

The paucity of resources. There are currently over one million older Americans living in almost 23,000 nursing homes in this country. Although this represents only 5% of the total population over 65, a more significant fact is that one-fourth of all persons over age 75 will enter a nursing home sometime in their lives (Lubin, 1975). In addition, with the vast increases of older Americans projected in the last quarter of the twentieth century, the total number needing nursing home care is bound to grow astronomically.

This vast number of institutionalized elderly is not a problem in itself, as most of the residents in nursing homes need some sort of professional care in a protective and therapeutic environment. What has become a major problem is the fact that a large proportion of these people are living in nursing homes which are marginally, if at all, geared toward providing for a decent quality of life for their patients. Especially problematic in this area is the quality of psychosocial care provided in nursing homes.

The majority of gerontologists who have attempted to create programmatic improvements in the "average" proprietary nursing home setting have almost universally cited the paucity of resources as the major impediment

(Wershaw, 1976). These nursing homes operate at the minimal standards as set and reimbursed by government and thus make the minimal expenses necessary to meet regulations. For example, while in a nonprofit, high expense geriatric center the activity program may be run by one or more occupational therapists; in a proprietary nursing home it could be directed by a 19-yearold ex-nurse's aide.

Proprietary and small nonprofit nursing homes have traditionally been most inadequately prepared in three major areas: staffing, rehabilitative services, and physical plant.

Staffing--The weaknesses of nursing home 1. staff are those of both quantity and quality. Inadequate number of staff is most often a direct result of the fact that nursing homes operate with between 70% and 80% of their patients paid for by state Medicaid funds (Brody, 1973), and thus staffing levels and amount of reimbursement for staff is a state prerogative. In other words, the state will reimburse the nursing home for staff as long as it maintains the minimal regulated levels; there is no incentive for increasing beyond this. Staff quality is also in great part a result of the fiscal policies--nursing home wages are the lowest in any health care profession and, for aides, are rarely above minimum wage levels. Thus, for nonprofessional
staff (aides, orderlies, housekeepers), wages for a very difficult and demanding job are no higher than those for much easier jobs on the outside; most of these staff members are forced by economic necessity to move to any higher paying job available, which contributes to the enormous turnover rate in these positions--as high as 90% per year (Schwartz, 1974). For professional nurses, lower wages contribute to high turnover and difficulty in securing top quality staff, but added to this is the fact that nursing homes are considered the lowest status jobs in health care. Because of the dual stigmata attached to "chronic care" and working with the elderly, it is extremely difficult to lure top quality nurses into the field. Finally, weaknesses in staff quality are in a large part the result of inadequate preparation, training, and supervision. York, Calsyn, and Fergus (1975) found that only 15% of the nursing home staff in the Lansing area reported any formal training in working with the elderly. Also, supervision by physicians and gerontological nurses was nonexistent.

2. <u>Rehabilitative services</u>, such as occupational and physical therapy, speech and hearing therapy, and mental health diagnosis, consultation and therapy are also lacking in nursing homes, largely because of the paucity of funds to support them. Nursing care is emphasized as primary, although Gottesman and Bourestom (1974)

found that only 2.1% of residents' time was spent in medical or nursing activities and 55% doing absolutely nothing. Thus, even though nursing homes are modeled after general hospital settings in treating the older person as a "patient" to whom things must be "done," there are few resources available to carry out these treatment tasks and to even begin to fulfill this role (Brody, 1973).

3. <u>Physical plant</u> resources of nursing homes are also far from adequate. Built on a strict cost per square footage formula, most nursing homes have a minimum of space for any but the most traditional uses: dining, sleeping, personal hygiene, and usually one lounge or activity area (Butler & Lewis, 1973). This has been perceived by Butler and Lewis (1973) as a special problem for those nursing home patients who have been released from state mental hospitals, which have relatively a wealth of resources.

Mental illness in nursing homes. Robert Butler (1973) and others (Kramer et al., 1973) have pointed out that it is no longer possible to distinguish the population of a nursing home from that of a mental hospital. In other words, the incidence of psychiatric illness and behavioral disturbance is easily as high among the nursing home population as it is among the geriatric

wards of a state hospital. According to Kramer et al. (1973), "by mid-1963, about 292,000 aged persons with mental disorders were residents in either long-stay psychiatric inpatient facilities or in nursing homes . . . 51% of these patients were in . . . mental hospitals and 43% in nursing homes and related facilities" (p. 450). Furthermore, according to Kramer's extensive research and estimates, by 1967 the quantity of mentally ill aged in nursing homes surpassed that in psychiatric facilities.

It is helpful to conceptualize this vast increase in mental health problems in the nursing home as arising from three separate sources: First, indiscriminate discharging of aged state hospital patients is a phenomenon of the 1960s and early 1970s which has swelled the rolls of most nursing homes. The number of aged in state mental hospitals decreased by 40% between 1969 and 1973 (Butler, 1975). Although much of the discussed intent for this mass discharge of the elderly was couched in the language of "community placement" and "appropriate levels of care," its actual impetus was economic: financial savings realized from moving older people into foster-care homes, boarding houses, and nursing homes have been significant in most states.

The second, and probably largest, source of mental disturbance in the nursing home are elderly patients experiencing first incidents of disorder.

This is especially problematic among the elderly because of the high risk for organic brain syndromes; in fact, researchers have found that the primary factors causing admission to nursing homes are symptoms of organic brain syndromes, such as confusion, disorientation, impaired judgment, etc. (York, 1976). In addition the nursing home environment itself often contributes highly to impaired functioning (Brody, 1973). Goldfarb (1963) found that as many as 87% of the patients in New York State nursing homes were manifesting symptoms of organic brain syndrome. One in three of these patients also exhibited behavioral disorders, and 49% were considered prime candidates for state hospitalization--this research having occurred when it was still possible to place an older person in a state hospital.

The third major component of mental health problems in nursing homes is that portion of behavior which can be attributed to the general difficulties in daily living. While scarcely qualifying as mental illness, there are many incidents arising from the close proximity of so many heretofore independent people, from the lack of decision-making opportunities, and from the angering and dehumanizing concomitants of both institutionalization and the losses in aging (Butler & Lewis, 1973).

The community mental health center and the nursing The federal community mental health centers prohome. gram, enacted in 1963 to provide a more community-based delivery of mental health services, would seem to be a natural source of support for the nursing home patient. As was established earlier, nursing homes do not have the resources to hire, nor are they reimbursed for or required to have the services of mental health personnel. On the other hand, the community mental health center (CMHC) was initially established to provide a wide range of mental health services to the "community"; those elderly living in nursing homes must be considered a part of the community, as the nursing home was the primary community placement target for state hospital discharge strategies. Originally, the CMHC was designated as the agent to care for discharged mental patients in the community. Thus, it seems only natural that the CMHC would have active programming and linkages with the nursing homes in its catchment area, as these homes provide a concentrated and high-risk population of individuals in need of a wide range of mental health services.

Unfortunately, as has been found to be the case with a great portion of the progress of CMHCs, the actuality is far inferior to the potential. Indeed, there has been a great reluctance on the part of CMHCs to work with the elderly in any capacity (Butler, 1975).

Fewer than 18% of CMHCs have created any sort of specialized geriatric program; less than 4% of the caseload of the average CMHC is made up of persons 65 years or older (Kramer et al., 1973).

The figures are just as dismal in the area of services to nursing homes as they are in generalized CMHC outpatient/inpatient services for the aged. Winn and Kessler (1974) conducted a study of CMHCs in three major metropolitan areas. While 60% of the CMHC administrators contacted replied that they were interested in expanding services to nursing homes, only two followed up the expressed interest with actual overtures. None of the CMHCs actually created any programs as a result of this contact.

Although no national data are available concerning the degree of CMHC involvement in nursing homes, some recent data from the HEW Region V area (six midwestern states) may shed some light on national trends. Of 57 federally funded CMHCs surveyed, only two had specific programs in nursing homes; three expressed more interest in using new funds for this area and had geriatric services divisions which planned to expand into nursing home services (York & Brand, 1976). Nevertheless, none of these latter centers had developed any organized program of nursing home services.

The reluctance of Community Mental Health Centers to extend services into nursing homes is likely a result of many factors. Foremost among these are the generally poor record of Community Mental Health Centers in serving the aged, which is often a reflection of nonexistent professional mental health training in gerontology, and the multiplicity of other demands on the average mental health center. In addition, there may be some reluctance on the part of the community mental health center to serve a proprietary agency and an equal reluctance on the nursing home side to work with what may be critical outsiders.

Nevertheless, many researchers and social planners have continued to argue for the natural linkage between CMHCs and nursing homes. The NIMH-HEW publication "Mental Health: Principles and Training Techniques in Nursing Home Care" (1972) continually identifies the CMHC as one of the major resources available to the nursing home. The Group for the Advancement of Psychiatry (1971) devotes a great portion of their booklet "The Aged and Community Mental Health" to the development of nursing home consultation programs. Probably the best summary of the potential benefits is provided by Yudin, Diamond, and Tucker (1973), who argue that such programs should include:

. . . utilization of mental health assistants from community mental health centers to serve as expediters rather than actual treating agents,

dealing with program planning, and special treatment of difficult or hard-to-reach patients. Teams from community mental health centers can serve many nursing homes on a rotating basis, developing occupational and recreational programs to complement other continuing treatment. Nursing home personnel would thus maintain responsibility for the administration of the program while benefiting from active liaison with a local CMHC. Such a liaison would be mutually advantageous, enabling both agents collaboratively to design and provide a wider range of clinical and preventive services and greater continuity of care than would otherwise be possible. (p. 428)

Finally, the 1975 Mental Health Act, P.L. 94-63, specifically mandates that CMHCs will create services for the elderly in their catchment area by 1977. As the nursing home provides an appropriate starting place by virtue of the magnitude of its problems and its lack of resources to deal with these, it will now be helpful to turn to an examination of how one CMHC began a comprehensive set of geriatric services through an initial interorganizational program with nursing homes.

<u>CMHC - Nursing home linkage: An example</u>. In 1974 St. Lawrence Hospital Community Mental Health Center received a research grant from the Michigan Association for Regional Medical Programs to develop and evaluate a program for providing services to local nursing homes. While this program has been described in much detail elsewhere (York & Fergus, 1976), a short description is appropriate here.

The Nursing Home Training and Consultation Project is composed of three major service areas, each designed to meet a specific area of need in nursing homes (see Appendix A). The first area, case consultation, is addressed to the most problematic or disturbed patients within the nursing home. Toward this end, the case consultation is comprised of a thorough assessment of the problem, both from the patient and the staff's point of view, and a series of conferences with the nursing home staff and/or the patient in order to plan a treatment approach. While not differing greatly from the most typical models of mental health case consultation, this specific consultation service is strongest in its emphasis on involvement of the nursing home staff in planning treatment recommendations as well as in carrying them out.

The second area of the Nursing Home Training and Consultation Project is <u>staff training</u>. While case consultation is designed to handle the most immediate and often the most unusual problem cases, staff training is geared toward providing the nursing home staff with a basic understanding of the processes of aging, the psychosocial aspects of care in nursing homes, the difficulties in adjustment to institutionalization, and specific techniques for dealing with elderly nursing home patients. Heavy emphasis in the staff training

program is placed upon communication skills with the elderly and approaches to use in dealing with typical problem situations.

The third area of the Nursing Home Training and Consultation Project is program development. Although it has been shown that staff training is usually capable of transmitting valuable and relevant information, it is not always clear whether this information can be translated into action in an organized and effective manner. Toward this end, the Nursing Home Project developed core groups of staff within each nursing home which are charged with planning programs for positive psychosocial care. These groups, made up of from 10 to 12 staff members from all levels and all shifts, are responsible for assessing problems within the home, evaluating what resources were available to deal with those problems, and developing programs, usually within an activity or occupational therapy model, to directly address these problems. Thus, while case consultation assists staff in dealing with the most disturbed patients and staff training provides skills for relating to all levels of patients, the program development services are intended to provide a more preventive level of programming to deal with such common problems within nursing homes as boredom, depression, and confusion.

The evaluation of the first year of the Nursing Home Training and Consultation Project was accomplished through a combination of experimental and quasiexperimental methods (Calysn, Fergus, & York, 1977). Results showed that case consultation was a significant method for decreasing problem behavior, for decreasing the need for relocation of patients for psychiatric care, and for improving staff skills in working with seriously disturbed patients. Staff training was found to be an effective method of increasing the knowledge and skills of staff, especially previously untrained aides and orderlies. It was also found that through the core group methods, it was possible to establish a strong group of internal program developers within a nursing home, despite the fact that this was a role to which nursing home staff were heretofore totally unaccustomed. Core groups were able to develop a broad range of programs directed at a very specific list of problems within the nursing homes.

As can be seen, the major interventions in this program were directed at the staff of nursing homes; in this sense, the CMHC served as a resource in staff development and skills training. In addition, however, each intervention strategy was designed to enable staff to have a more positive impact on patients, whether directly as in case consultation, or indirectly as in core group

development. For this reason, other assessment techniques were intended to measure and assess the impact of the program on the nursing home residents themselves; through this it was found that there was a significant decrease in depression and in psychotic/inappropriate behavior and a significant increase in activity level (York & Fergus, 1976).

Summary

A review of the literature on interorganizational relations revealed no systematic empirical studies of attempts to increase or improve interactions among agencies. A fair amount of descriptive research was conducted on human services agencies, especially during the War on Poverty era; this research revealed several concepts which may be crucial in any attempt to increase the interaction among organizations, such as this proposed study on increasing interaction between community mental health centers and nursing homes.

Resource interdependence, as noted by Lehman (1975) and Reid (1969), seems to be a major factor influencing coordination. Especially in health and human services agencies, resources in the categories of funds, staffing, and clients are often scarce, and agencies must look beyond their boundaries in order to meet their goals or objectives. The logical step from

here, although not a step postulated widely in the literature beyond the effort of Levine et al. (1969), is that interagency coordination efforts must first focus on revealing this resource interdependence to target agencies.

<u>Goal and task similarity</u> were hypothesized by Evan (1971) and Reid (1969) to be either prerequisites or indicators for interaction. Indeed, Tornatzky and Lounsbury (1973) found a high correlation between the perceived similarity of goals and tasks between organizations and the amount of interaction. For this reason, it was deemed promising to investigate the manipulation of this perceived goal/task similarity dimension in an attempt to increase the propensity for interaction.

Unfortunately, these theoretical concepts have not been operationalized into techniques for promoting interorganizational interaction. Thus, the author has proposed the investigation of a newly created interorganizational workshop technique entitled Goal Congruency Training (GCT). GCT combines the theoretical perspectives mentioned above with certain intergroup techniques culled from the organization development literature to form a workshop designed to lead toward a higher perception of goal congruency among agencies and, thus, to greater interaction. The community mental health center and the nursing home are two agencies which should be, but are not, working together. Therefore, the author proposes an examination of the efficacy of this GCT technique on these two types of organizations, especially as the author's previous experience and research have indicated a higher degree of interdependence and similarity than acknowledged. Following are the hypotheses and the methodology of this investigation.

Hypotheses

Hypothesis 1:

An interorganizational joint workshop, employing intergroup and team building organization development techniques, will be an effective method of increasing interaction between community mental health centers (CMHCs) and nursing homes by: (a) increasing goal congruency awareness and (b) increasing task similarity awareness

Hypothesis 2:

CMHCs and nursing homes which participate in an OD workshop will have a greater probability of establishing an interorganizational planning team, as compared to CMHCs and nursing homes which take part in a joint workshop emphasizing only specific models for interaction (as described above with the St. Lawrence project) and without any organization development activities.

Hypothesis 3:

CMHCs with more community-based programming and a greater community orientation will have a greater probability of developing a nursing home program.

Hypothesis 4:

CMHCs which are historically more innovative will have a greater probability of developing a nursing home program.

CHAPTER II

METHODS AND PROCEDURES

Sample

Twenty-two community mental health centers served as the focal participants in this study. They were volunteers from the total population of 59 CMHCs which are federally funded in HEW Region V (Ohio, Indiana, Illinois, Wisconsin, Minnesota, Michigan). Before volunteering, CMHCs were eliminated from the pool if they already were regularly serving nursing homes (n = 2) or if they had received funding for such a program and were presently involved in implementation (n = 1).

As Table 1 indicates, there were 150 participants in all in this study representing the 22 CMHCs. A CMHC staff member was only considered an active participant if he or she was in attendance at the workshop. Of the 150 attending workshops, only 85 completed both pretest and follow-up questionnaires; 26 completed the pretest questionnaire and no follow-up, while 29 did the opposite, failing to complete pretest evaluations.¹

¹In addition, 103 nursing homes were represented at the workshops. It was originally intended that a

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Participants in Study

Total attending workshops	150
Number completing pretest and follow-up assessment	85
Number completing only pretest	29
Number completing only follow-up	26
Number completing neither pretest nor follow-up but only workshop	
assessment	10

Experimental Design

The <u>dependent variables</u> assessed were the degree of interaction between these focal CMHCs and the nursing homes in their catchment area, and, following this, the amount of joint programming. Further discussion of the specifics of definition and measurement of these dependent variables follows below.

The <u>independent variable</u> was the differing degree of focus on goal congruency and intergroup team building which occurred in each of two separate treatment conditions, also described fully below: (1) an organizational development Goal Congruency Training Workshop and (2) a Programming Workshop. Given these two treatments, the

parallel set of data would be collected from nursing homes and questionnaires were thus sent to all. Unfortunately, however, the return rate on pretest (less than 20%) and follow-up (less than 50%) questionnaires was so poor that these data were eliminated from further analysis.

design consisted simply of two cells into one of which each of the focal CMHCs was randomly assigned (see Figure 1).

Experimental	Conditions
Goal Congruency Training	Programming Workshop
n = 11	n = 11

Figure 1. Experimental design

Treatment Conditions

As noted, the independent variables in this study were manipulated by two separate treatment conditions, varying from each other along one major dimension: the degree of organizational development activity in which the CMHCs and nursing homes took part.

1. <u>Goal Congruency Training Workshop</u> (High OD condition): As described in Chapter I, Goal Congruency Training consisted of organization development activities such as team building and intergroup techniques designed to assist CMHCs and nursing homes in the establishment of a planning group. GCT workshops included representatives of both the CMHC and nursing homes in its catchment area; thus, the manipulations were intended to create a state of "goal congruency" and communication leading to interorganizational interaction. The final session of each GCT workshop consisted of a "run-through" of a sample planning group meeting, with the workshop leader assisting the participants in actually applying the interorganizational skills they were to later use.

A sample schedule for the GCT workshop is shown in Table 2. In addition, a specification of the GCT organization development activities follows:

(a) "Goals and Barriers in Serving the Older Client"--In this exercise, the representatives of the CMHC and the nursing homes divided into separate groups to brainstorm a list of answers to several broad questions. These included questions such as "What are the major mental health needs of the older client?" and "What barriers keep you from being able to meet these needs?" The groups then reconvened and the workshop leader compared the different organizations' lists. An emphasis was placed on the often striking similarities between these lists, and the participants were asked to join in analyzing the implications. The intended outcome was a heightened awareness of the areas of similarity among these organizations.

(b) "Components of a Model Program"--This section of the workshop was more didactic than the previous as it was designed to present to the participants some specifics of joint programming. In the GCT workshop the leader promoted a greater degree of discussion and

Table 2	2
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Comparison	of	Workshop	Schedul	les
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Time	GCT Workshop	Programming Workshop
9:00	Introductions & Initial Char	ge Introductions & Initial Charge
9:30	Exercise"Mental Health Needs of Older Patients"*	Lecturette"The Mental Health Needs of the Older Patient & the Nursing Home"
10:15	Discussion of Exercise with Consultant	Discussion of Lecturette with Consultant
10:30	Coffee Break	Coffee Break
11:00	Exercise"Components of a Joint Program	Lecturette"How CMHC's and Nursing Homes Have Interacted" Part I
11:30		Discussion of Lecturette
12:00	Lunch	Lunch
1:00	Exercise"Organizational Mirror-Fishbowl of Goals, Tasks, and Benefits of Working Together"	Lecturette"How CMHC's and Nursing Homes Have Interacted" Part II
2:00		
2:30	Break	Break
3: 00	Exercise"A Sample Planning Group Meeting" [*]	Exercise"A Sample Planning Group Meeting discussion
4:15	Evaluation	Evaluation
4:30	Adjournment	Adjournment

*See text for explanation.

interaction by using a more open-ended format than in the other condition. Participants were also presented a copy of the manual "Community Mental Health Centers and Nursing Homes: Guidelines for Cooperative Programs" to give them more specific programming information.

(c) "Organizational Mirror with Fishbowl--Goals, Tasks, and Benefits of Working Together"--This exercise focused on each group's perceptions of the goals and tasks of the other group, and then on the perceived benefits of interaction. Initially, the CMHC staff met in the center of the fishbowl with the nursing home representatives on the outside listening, with the task of discussing their goals in working with nursing homes and their perception of what benefits could accrue from this type of interaction. After this discussion, approximately 20 minutes, the two groups changed positions and the nursing home staff, now on the inside, addressed the same issues. Finally, the two concentric circles combined into one, and the workshop leader conducted an examination of the potential barriers to further interaction as well as a discussion of other issues raised in the fishbowl. Through this exercise, the two groups could begin to listen to and appraise the styles of thought of each other, and once again establish a stronger bond of communication and perceived communality.

(d) "A Sample Planning Group Meeting"--In the weeks following the workshop, the goal of the two groups was to develop an inter-agency planning group to design their future joint programming. This exercise provided a "guided tour" through a planning group meeting in order to illustrate and establish the specific skills necessary for such a group to function properly. Thus, this exercise forced the participants to actually demonstrate the behaviors expected of them in future months. The agenda for this first meeting was not artificial, however, but was geared toward setting up future meeting times, membership, agendas, etc. The workshop leader provided stronger direction in this meeting so as to get the group started successfully.

2. <u>Program Development Workshop</u> (Low OD condition): This condition consisted of a workshop centered solely around programming specifics, such as guidelines for interagency cooperation, techniques for consultation and training in nursing homes, etc. A certain degree of informal interorganizational development existed solely because this manipulation at least pulled together the principal parties involved, the CMHC and nursing home staff representatives; nevertheless, no specific intergroup or team building activities occurred, leaving this essentially similar to the straight "workshop" or

training model. All participants in this condition as well as in the OD condition received a copy of the Manual. Following is a further explanation of programming activities at this workshop:

(a) "The Mental Health Needs of the Older Patient and the Nursing Home"--This short lecture looked at the needs of the average older patient and the benefits of interaction between CMHCs and nursing homes. A short discussion and question period followed.

(b) "How CMHCs and Nursing Homes Have Interacted"--These two lectures took a closer look at past programs between CMHCs and nursing homes, pointing out some of the benefits and some of the problems. The discussion following focused on the participants' perceptions of the examples presented. In addition, some questions were directed toward the practicality of such a program in each community, but they were largely deferred to the planning group meeting.

(c) "Sample Planning Group Meeting"--This exercise was essentially identical to the final exercise in the OD condition. It was included in order to assure that participants in each condition had had an equal amount of actual involvement in planning together during the workshop so that this would not be a confounded factor with the goal similarity manipulations.

As can be seen from Table 3, the workshops were not only different in their format but, beyond this, in their general characteristics and atmospheres. For example, from the beginning, participants in the ODoriented workshop were told that their purpose was to more closely examine their organizations as this would relate to interagency programming; on the contrary, participants in the traditional workshop were introduced to the day by the expectation that they would learn more about the specific steps required in developing interagency programs. This distinction between a processoriented focus and an information-oriented focus was continued through the day's activities. Thus, in the OD workshop, a portion of one of the exercises was devoted to having the participants discuss among themselves the problems which were potentially created by interagency cooperation and then brainstorm possible solutions to these problems. On the other hand, the traditional workshop included a portion of one lecture devoted to potential problems and their solution. It can be seen, in the former approach then, that participants were given a much greater stake in contributing while at the same time they could learn more about each other as individuals and as organizations through these contributions.

Table 3

Comparisons between Two Workshop Conditions

		Type of Workshop	
		Goal Congruency Training- Organization Development	Program-Oriented Workshop
	Initial Charge and Definition	To create planning group to begin programming	To discuss need for programs and steps in programming
	Commitment Level	To make comments and decisions publicly	To discuss and learn, but make no decisions
r Characteristic	Behaviors	<pre>exercises designed to: -define goals & needs -look at inter- agency perceptions -create planning group -define potential problems</pre>	<pre>lecturettes & dis- cussions on: -needs for program- ming -aspects of planning -specifics of pro- grams -potential problems</pre>
Dimension	Degree of Interaction	Fishbowl and goal defining exercises with high inter- action "Meet each other and work together"	Discussion and lectur- ettes with moderate specific limited time for interaction "Meet each other and <u>learn</u> together"
	Information transmitted	Participants referred to Manual "emphasis on process"	Much information on specifics of programs needed "emphasis on infor- mation

Designation of Participants

As mentioned before, 22 CMHCs were selected to comprise the CMHC sample. According to a random selection procedure, letters requesting participation were sent to each of the eligible CMHCs in Region V. These letters were sent out in waves of 18 at a time in order to keep as uniform as possible the time lag between the decision to participate and the treatment. In addition, sampling for the two conditions was done randomly within blocks of four CMHCs; these blocks were filled chronologically by the quickness of decision to participate. In this way, some control was introduced over the possible differences in eagerness or desire among CMHCs according to latency of response.

Initially, a short cover letter from the Department of Health, Education, and Welfare, Region V, ADAMHA Branch, introduced the project to each CMHC director and urged participation (Appendix B). Attached to this was a letter from the Research Project soliciting participation, and several copies of a brochure describing the project (Appendix C). Each CMHC director who agreed to take part in the service and research aspects designated one staff person as "Contact Person"; named seven other staff who would take part and gave each a copy of the brochure; and returned a "Staff Contact Form" (Appendix D) with all designated names on it. Random assignment to

treatment conditions occurred upon receipt of the "Staff Contact Form," which served as an agreement to participate.

Project staff then immediately telephoned the "Contact Person," who was responsible for scheduling a date for a workshop; for compiling names and addresses of nursing homes and soliciting their staff's attendance; and for assisting Project staff with data collection by completing some instruments alone and by distributing others to both CMHC and nursing home staff.

Through this contact person, the list of individual participants was compiled, and pretest data collection forms were mailed out. The requested staff for each workshop consisted of the following:

> CMHC--6-8 staff--coordinator for consultation and education services and staff for consultation and education services coordinator of any geriatric services division any staff of geriatric services division aftercare coordinator any other designated CMHC staff, to make a total of 10 representatives

Nursing Home--10-12 staff--nursing home administrator from each home director of nursing from each home possibly inservice director or activity director

Workshop size ranged from 13 to 20 people, with the mean number of attendees being 16.1. From 2 to 9 nursing homes were represented, with a mean of 4.6 per workshop. No nursing home was to be eligible to participate in a workshop without attendance of the administrator or his designate, although in practice 57% of the nursing homes failed to meet this criteria. Table 4 illustrates the timetable of operations and provides an overview of scheduling and data collection procedures. In addition, Appendix E provides a closer look at these procedures.

Table 4

Timetable

Weeks	
0	Initial Contact Letter and Brochure Mailing
2	Solicit Final Decision to Participate
3	Contact the "contact person" for: scheduling nursing home names, miscellaneous infor- mation
4	Mail out "Pretest Instruments"
8	Conduct Workshop
8	Collect Posttest DataWorkshop
12	First Follow-up Call, Outcome/Process Interview
20	Second Follow-up Call, Outcome/Process Interview
20	Mail out "Follow-up Instruments"

Scheduling Procedures

The contact person designated by the CMHC director after the initial telephone call served as a liaison between the Project, the CMHC, and its nursing homes. Workshops were scheduled initially through correspondence between the Project staff and the CMHC contact person. It was the responsibility of this contact person to arrange for the participation of the nursing homes in his catchment area, as well as for the place and exact time of the workshop. The contact person sent, at least five weeks before the workshop, a list of all scheduled participants in order to assist the Project staff in its data collection.

Measurement

The first portion of this section on measurement examines the utilization and organization of instruments in this study. The second section looks at how the data were organized into measures of the independent variables (i.e., <u>manipulation checks</u>), <u>descriptive</u> measures, <u>pro-</u> <u>cess</u> measures, and dependent variables (<u>outcome</u> measures).

<u>Instruments</u>. For the purposes of data collection, data in this study were organized into five separate instruments.

1. "Initial Organizational Assessment"--This questionnaire was completed before the workshop

intervention by the CMHC contact person to provide descriptive data concerning the mental health center (Appendix F).

2. "Goal-Task Matrix"--This instrument, assessing the independent variables described above, was completed by each of the designated participants to the workshop three separate times: four weeks before the workshop, at the end of the workshop day, and 12 weeks following the workshop (Appendix G).

3. "Interaction Questionnaire"--The "Interaction Matrix" and "Index of Cross-Visiting," both measures of outcome, were included in this instrument. This was completed by each of the designated participants four weeks before the workshop and 12 weeks following. The instrument was not administered on the day of the workshop because there was no reason to suspect that the intervention would have an immediate (one-day) effect. A further question on the follow-up administration concerned perceptions of changes in interaction (Appendix H).

4. "Workshop Evaluation"--Each participant at the workshop completed this at the end of the day. Data collected included some descriptive measures, as well as an assessment of the process of the workshop (Appendix I).

5. "Follow-up Interview"--This telephone interview was conducted by a trained graduate student with

each CMHC contact person at 4-week and 12-week intervals following the workshop. Much of the data collected concerned the processes involved in establishing interaction after the workshop. In addition, the interview looked at outcomes as the contact person reported the data concerning number of planning meetings and level of joint programs begun (Appendix J). Table 5 describes further the time of administration of each instrument by treatment condition; Table 6 breaks down each instrument into data collected and method of administration.

Manipulation checks (independent variables). The major purpose of these measures was to determine whether the organization development techniques in the experimental manipulation were able to produce their intended effects, in other words, increasing the perceptions of goal and service similarity. Two specific measures were utilized for this purpose:

1. <u>Perceived Goal Similarity</u>.--This matrix measure was completed by each participant in the study at three intervals (see Table 5). Each subject's raw score of his perceptions of similarity with each of the other organizations was summed and the arithmetic mean was computed, providing for each participant an "Index of Goal Similarity." Total agency indices were computed by aggregating the individual scores, although as will

ondition		Followup (12 weeks)		Goal/Task Matrix	Interagency Interaction	Followup (also at 4 weeks)		Goal/Task Similarity	Interagency Interaction	Followup (also at 4 weeks)
me for Each Treatment Co	Time	Posttest (at workshop)		Goal/Task Matrix		Workshop		Goal/Task Matrix		Workshop
Measurements at Each Ti		Pretest (Mail)	Initial Assessment	Goal/Task Matrix	Interagency Interaction		Initial Assessment	Goal/Task Matrix	Interagency Interaction	
			ר uo	atio men q	ous dole zine noi:	Vondi Deve Deve Deve	ນດ ກັນ ມີເອັນ	eatn mmir atic qo	ksh mro fra fra fra fra fra fra fra fra fra fra	or¶ ful IOW

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Table 5

				e e	
	Variables Assessed	intraorganizational variables size age of agency innovativeness commitment to aging C & E programs	perceived similarity of goals perceived similarity of services	degree of interaction number of cross-visits perception of change in interactio (followup only)	Personal variables age education length of working contact with elderly
- 	Method Given	Mail	Mail in person mail	mail in person mail	in person
	Time Given	Pretest	Pretest At workshop Followup	Pretest Followup	At workshop
	Completed by	Contact Person (CMHC)	Workshop attendees	Workshop attendees	Workshop attendees
	Name of Instrument	Initial Assessment (IA)	Goal/Task Matrix (GCT)	Interagency Interac- tion (Grid)	Workshop Evaluation

Characteristics and Details of Instruments

Table 6

1	56	1
Variables Assessed	Process of workshop clarity interest interest & desire for programming with NH funds funds innovativeness level of resistance	Development of Planning Group-Process membership & decision-making frequency of meeting resistance (if no group especially) CMHC contact with nursing homes-outcomes number of planning group meetings types of joint programs
Method Given		Telephone
Time Given		Followup (4 wks/12 wks)
Completed by		Contact person (CMHC)
Name of Instrument		Followup Interview

Table 6

Continued

be seen later, most initial analyses were completed in a nested format in order to preserve individual variation.

2. <u>Perceived Service (Task) Similarity</u>.--This matrix measure was scored and aggregated in an identical manner to Goal Similarity and was also administered at pretest (four weeks before workshop), immediately following the workshop, and at the 12-week follow-up point.

Descriptive measures. These variables were intended to describe characteristics of both the organizations and individuals who participated in the workshops. Although most of these were of little conceptual interest, they were considered for the possible confounding effects they may have exerted on the outcome. In addition, several of these were mentioned in the literature as being germane to interagency cooperation.

1. <u>Organizational parameters</u> measured included the age and size of the community mental health center; the types and balances of the CMHC programs, and the type of catchment area served.

2. <u>Innovativeness</u> of the CMHC was assessed by a self-report of the number of new programs begun by the CMHC in the last two years.

3. <u>Community orientation</u> of the CMHC was assessed by the proportion of the total budget of the organization allotted to consultation and education activities.

4. <u>Geriatric orientation</u> of the CMHC was assessed by aggregating the percentages of time serving the elderly of each participant from that agency as well as by computing the proportion of consultation and education time allocated to geriatrics. Also included here was a measure of the participants' satisfaction with their current geriatric programming.

5. <u>Individual descriptors</u> included age, education level, length of time employed, and staff position.

Process (intervening variable) measures. The data gathered in this area examined some of the processes involved in the workshop and the further interaction, including the development of the planning group.

1. <u>Workshop Process Assessment</u> included the individual participant's judgment of the effectiveness of the workshop intervention in addition to his perceptions of the prospects for further interaction based upon the workshop experience. Further measurement in this area included the attendance at and composition of the workshop and a measure of the outcome of the workshop, i.e., whether a planning group was formed and meetings were scheduled.

2. <u>Follow-up Process Assessment</u>. Data in this category examined some of the processes involved in further interaction among the agencies. This included
the size and composition of the planning group; perceptions of barriers to further interaction; amount of time spent in discussion of joint programming with staff of other agencies; and attitudes toward the feasibility of further interaction.

Outcome measures. Data collected in this area were intended to assess the actual outcomes of the workshops, i.e., the degree and type of joint planning/programming between the agencies.

1. <u>Interaction Matrix</u>. This matrix measure involved each participant in assessing his organization's level of interaction with each other organization in his workshop cell. Items on this scale, adopted from a previous study by Tornatzky and Lounsbury (1973), ranged from "No Interaction" to "Plan and Conduct Joint Programs Together." Each individual respondent was assigned an "Interorganizational Interaction" score by computing the arithmetic mean of his scores on this matrix. The organization's interaction score was also computed by aggregating all individuals' scores.

2. <u>Index of Cross Visiting</u>. Each respondent was asked to report on a matrix the number of times monthly that he visited or was paid a visit by staff from each of the other agencies. Scores were computed and data aggregated in the same manner as for the Interaction Matrix.

3. <u>Number of Planning Meetings</u>. At both 4-week and 12-week follow-up intervals, the CMHC contact person reported the number of interagency planning meetings which had taken place.

4. <u>Perception of Interaction</u>. Each respondent rated on a 5-point Likert scale his impression of changes in interaction following the intervention at the 12-week follow-up point.

5. <u>New Joint Programming</u>. Each contact person also reported the types of joint programs which had begun between the agencies. These were scored on a dichotomous basis as to whether any new programs had developed beyond the planning meeting stage.

CHAPTER III

RESULTS

Analysis Procedures

The following chapter is intended to organize and describe the results of the data analysis for the current experiment. For purposes of clarity, data have been organized into several different categories for presentation. First, the data which allow for some level of pretest, or before-intervention, comparisons of the individuals and groups in the two conditions are presented. Second are the results of the manipulation check on the independent variables. Third, the results of the experimental comparison of the two different treatments are looked at through the outcome or dependent variables. Fourth, further analysis of the dependent variables is accomplished by examining the relationship of these factors to much of the associative and descriptive data gathered. Finally, some of the processes involved in developing interorganizational interactions are examined.

In addition, several often parallel strategies for data analysis have been used throughout this section of the study. Multiple techniques for analysis were necessitated by the multiple levels of measurement utilized.

Much of the data gathered in this study was descriptive at the organizational level; this information was either gathered from one respondent (the contact person) or could conceptually be aggregated from multiple individual reports to represent one "organizational (CMHC) score." An example of this type of data is the item measuring "amount of time working with the elderly." While each individual participating in the study reported his personal score on this item, these scores could conceivably be aggregated across one organization to obtain an organizational index of time spent in geriatrics. Therefore, all data at the organizational level were analyzed utilizing the appropriate parametric (one-way analysis of variance, t-test) or nonparametric (chi-square) statistics.

For the critical independent and dependent measures, however, it was felt that aggregation of scores, as well as being conceptually unsound, could mask the effects of individual score variances with each organizational unit. For this reason, a nested analysis of variance was performed, with separate error terms and <u>F</u>-ratios being computed for subjects, CMHC, and treatment effects. In situations in which there was a significant within-CMHC effect, this type of analysis, although conservative, is the only manner to insure a theoretically accurate comparison. When this within-CMHC effect was not significant, however, it is overly conservative to utilize solely the mean square for

the within-CMHC factor as the error term in computing the \underline{F} -ratio for the main (treatment) effects. In these situations, therefore, the error term used was a pooled term calculated by adding the mean squares for both lower level effects (CMHC's and subjects) and dividing by the sum of their degrees of freedom. In this manner, a less conservative but nevertheless statistically sound estimate of the main effects could be made. Those calculations where a pooled error term was used have been noted throughout.

Further analysis of the data made use of correlational techniques, most notably the Pearson product-moment correlation (r). Correlations for data gathered from all individuals could only be interpreted after aggregating to obtain organizational indices. Thus, some of the individual data which could not be meaningfully aggregated were excluded from the correlational analyses. In addition, the reader should take note that aggregated data were not integrated with the individually reported data because of measurement incompatibilities.

Pretest Comparisons

Although subject attrition and changeover made it impossible to utilize pretest scores as covariates on any of the independent and dependent measures, these were analyzed separately in order to illuminate any potential differences between groups. In addition, comparisons were

made between the two conditions on organizational characteristics and characteristics of the actual workshop intervention.

Independent and dependent measures. As can be seen from the analyses of variance in Tables 7, 8, 9, and 10, there were no significant pretest differences between the OD and the traditional workshop conditions on the two major measures of the independent variables, Goal Similarity (F = .052, df = 1, 20) and Service Similarity (F = .051, df = 1, 20), or on the two major outcome variables, Interaction (F = .078, df = 1, 20) and Cross-Visiting (F = .19, df = 1, 20). For each of these four measures, however, there were quite significant CMHC effects, revealing the large variations across the entire sample, as may have been expected.

<u>CMHC characteristics</u>. t-Test and Chi Square statistics were used to examine the two conditions for differences in several organizational characteristics; the groups were not found to have any significant differences on any of these measures (Table 11).

<u>Workshop characteristics</u>. Such factors as the type and amount of attendance at the workshop were compared to reveal any differences between the two conditions; Table 12 reviews these data, which showed no significant factors.

Analysis of Variance--Goal Similarity--Pretest

Source of Variation	Sum of Squares	DF	Mean Squares	F
Treatment	.191	1	.191	.052
CMHC's	73.57	20	3.68	2.65*
Subjects	116.83	84	1.39	
	Cell Mean	<u>s</u>		
OD gr Tradi	oup tional grou	p 2	2.79 2.88	
То	tal	2	2.83	

*p < .001

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Table 8

Analysis of Variance--Task Similarity--Pretest

Source of Variation	Sum of Squares	DF	Mean Squares	F
Treatment	.166	1	.166	.051
CMHC's	64.88	20	3.24	2.05*
Subjects	126.77	80	1.58	
	Cell Mean	s		
OD (Trac	group ditional grou Fotal	2 p 2 2	.76 .67 .71	

Analysis of V	VarianceInteraction	MatrixPretest
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Source of Variation	Sum of Squares	DF	Mean Squares	F
Treatment	.432	1	.432	.078
CMHC's	110.03	20	5.50	2.93*
Subjects	167.36	89	1.88	
	Cell Means	<u> </u>		
OD gı Tradi	coup itional group	þ	2.94 3.07	
Тс	otal		3.00	

*p < .001

Table 10

Analysis of Variance--Cross-Visiting--Pretest

Source of Variation	Sum of Squares	DF	Mean Squares	F
Treatment	.341	1	.341	.19
CMHC's	36.27	20	1.81	1.93*
Subjects	80.89	86	.941	
	Cell Mean	S		
OD g Trad	roup itional grou		.77.88	
T	otal	•	. 82	

Variable	df	t	р
Years of Existence of CMHC	20	.970	N.S.
Staff Size of CMHC	20	.181	N.S.
Innovativeness New Programs	20	1.17	N.S.
Geriatric Admissions	20	.199	N.S.
Geriatric Staff	20	1.78	N.S.
Geriatric Clients	20	.480	N.S.
Consultation-Education Budget	20	.678	N.S.
Consultation-Education in Geriatrics	20	1.562	N.S.
Variable	df	x ²	р
Geriatrics Grant	1	.00239	N.S.
Nursing Home Program	1	1.234	N.S.

Pretest Comparisons--CMHC Characteristics

Variable	df	t	p
Total People at Workshop	20	.435	N.S.
CMHC Staff at Workshop	20	.125	N.S.
CMHC Administrative Staff at Workshop	20	.288	N.S.
Nursing Homes Represented at Workshop	20	1.088	N.S.
Nursing Home Administrative Staff at Workshop	20	.717	N.S.
Total Nursing Home People at Workshop	20	.895	N.S.

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Table 12

Pretest Comparisons--Workshop Characteristics

Attrition/addition analysis. As can be recalled, there was a rather large influx of subjects to the experiment for posttest--only analysis who had failed to complete the pretest. In this analysis, scores on the major posttest variable, degree of interaction, were compared for those who had completed both pretest and posttest versus those who had completed the posttest only. No significant differences were found (F = 1.071, df = 1, 96).

Independent variables: A manipulation check. As has been noted above, two measures, Goal and Task Similarity, were assessed at three periods to ascertain the mediating effects of the intervention; in other words, they served as a manipulation check to determine whether the workshops were having their intended effect. Tables 13 and 14, independent variables immediately following the workshop, and Tables 15 and 16, at 12-week follow-up, show that there indeed were significant differences in perceived Goal and Task Similarity between the two groups and that these differences persisted at both follow-up measurement periods. For Goal Similarity, the F ratio post-workshop was 7.40, with df = 1, 20; at 12 weeks, F = 4.85, df = 1, 102 using the pooled analysis described above. Both are significant at the .05 level. For Task Similarity, post-workshop, F = 4.42, df = 1, 144 pooled, p < .01; at 12 weeks, F = 4.54, df = 1, 101 pooled, p < .05. In all situations, a review of the cell means

Analysis of Variance--Goal Similarity--Post-Workshop

Source of Variation	Sum of Squares	DF	Mean Squares	F
Treatment	17.84	1	17.84	7.398*
CMHC's	48.23	20	2.41	1.886*
Subjects	158.56	124	1.28	
·····				

Cell Means

OD group Traditional	group	4.19 3.48
Total		3.84

*p < .05

Table 14

Analysis of Variance--Task Similarity--Post-Workshop

Source of Variation	Sum of Squares	DF	Mean Squares	F
Treatment	7.44	1	7.44	3.132
CMHC's	47.48	20	2.37	1.521
Subjects	188.88	121	1.56	
Treatment	7.43	1	7.43	4.42*
Pooled CMHC-Subjects	236.36	141	1.68	
	Cell Mean	ns		
OD gr Tradi	oup tional grow	3 up 2	.36	
То	tal	3	.13	

Tab	le	15

Source of Variation	Sum of Squares	DF	Mean Squares	F
Treatment	9.23	1	9.23	4.18
CMHC's	44.14	20	2.21	1.21
Subjects	149.95	82	1.82	
Treatment	9.23	1	9.23	4.85*
Pooled CMHC-Subjects	194.09	102	1.90	
	Cell Mea	ns		
OD gr Tradi	oup tional gro	up 3	3.74 3.12	

Analysis of Variance--Goal Similarity--12 Weeks

*p < .05

Table 16

3.43

Total

Analysis of Variance--Task Similarity--12 Weeks

Source of Variation	Sum of Squares	DF	Mean Squares	F
Treatment	7.72	1	7.72	3.47
CMHC's	44.48	20	2.22	1.42
Subjects	126.71	81	1.56	
Treatment	7.72	1	7.72	4.54*
Pooled CMHC-Subjects	171.20	101	1.70	
· · · · · · · · · · · · · · · · · · ·	Cell Mear	ns		· · · · · · · · · · · · · · · · · · ·
OD gr Tradi	oup tional grou	1p 2	8.41 2.83	
То	tal	3	3.12	

revealed that the OD group perceived greater Goal and Task Similarity, as predicted. The means also indicate that the perceptions of goal similarity for both groups declined slightly over time, while task similarity remained almost the same.

Dependent variables. From the above, it can be seen that the two workshop methodologies were indeed creating the differential effect on perception of Goal and Task Similarity as intended. The next part of the analysis was concerned with determining whether the ODfocused workshop was able to create more interorganizational interaction as hypothesized. Several different outcome measures were analyzed.

Interaction Matrix

This measure was examined with a nested analysis of variance at the 12-week follow-up point. As Table 17 indicates, there were no significant treatment effects as reflected in this variable (F = .184, df = 1, 20). There remained, however, significant variation across CMHCs in the sample, as was found in the pretest data, although this variation was not as great after the intervention (F = 1.838, df = 20, p < .05). One can see from the mean interaction scores, however, that interaction increased equally for both groups following

Analysis of Variance--Interaction Matrix--12 Weeks

Squares	DF	Mean Squares	F
.72	1	.72	.184
78.10	20	3.90	1.838*
186.95	88	2.12	
Cell Mean	s		
roup litional grou	р 3	8.81 8.97	
otal	3	8.89	
	Squares .72 .78.10 186.95 <u>Cell Mean</u> roup itional grou otal	SquaresDF.72178.1020186.9588Cell Meansroup3itional group3otal3	Squares DF Squares .72 1 .72 78.10 20 3.90 186.95 88 2.12 Cell Means 3.81 itional group 3.97 otal 3.89

*p < .05

Table 18

Analysis of Variance--Cross-Visiting--12 Weeks

Source of Variation	Sum of Squares	DF	Mean Squares	F	
Treatment	3.78	1	3.78	.722	
CMHC 's	104.08	20	5.20	2.66*	
Subjects	150.45	77	1.95		
	Cell Mean	S			
OD Tra	group ditional grou Total	p 1 1	.62 .22 .42		

the workshops, from 2.94 to 3.81 on a 5-point scale for the OD group, from 3.07 to 3.97 for the other.

In addition, a repeated measures analysis of variance was completed on this variable for those subjects who had completed both pretest and follow-up questionnaires; no significant time or treatment interaction differences were found.

Cross-Visiting

This measure was also analyzed in a nested analysis of variance format (see Table 18, page 73). Once again, there were no significant treatment (workshop) effects (F = .722, df = 1, 20), while the variation across CMHCs remained great (F = 2.66, df = 20, 77, p < .001). It can be seen from examining the group means, however, that interaction as assessed by this measure increased for both groups following the intervention, from a mean of .77/month to 1.62 for the OD group, and from .88 to 1.22 for the traditional group.

Number of Planning Meetings

This variable, as assessed from the contact person at 4-week and 12-week follow-up, was examined by t-test comparison. As Table 19 elucidates, there were no significant differences between groups at either time (t = 1.11, df = 20 at 4 wks., t = .733, df = 20 at 12 wks.). For this variable, the Traditional workshop group tended

Table	19
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t-tests--Planning Meetings at 4 & 12 Weeks

Variable	X OD	\overline{X} Trad.	X Total	df	Т	р
Planning mtgs 4 wks	1.00	1.55	1.27	20	1.11	N.S.
Planning mtgs 12 wks	1.91	2.27	2.09	20	.733	N.S.

Table 20

Analysis of Variance--Perception of Interaction Changes--12 Weeks

						_
Sourc	ce of Variatio	on Sum of Squares	DF	Mean Squares	F	_
	Treatment	1.29	1	1.29	.854	
	CMHC's	30.22	20	1.51	2.692*	
	Subjects	46.60	83	.561		
		<u>Cell Me</u>	ans			-
		OD group Traditional gr	oup	2.23 2.00		
		Total		2.12		

*p < .001

to have had more interaction at both times; also, interaction for both groups increased from the 4-week to the 12-week period.

Perception of interaction changes. This outcome variable, rated individually by each participant, was also analyzed in a nested analysis of variance format. Once again, there were no significant treatment effects between group differences (F = .854, df = 1, 20), but there were significant effects across CMHCs (F = 2.692, df = 20, 83, p < .001) (Table 20, page 75).

Joint programs. This dichotomous measure, as reported by each contact person, was analyzed at 4-week and 12-week follow-up using chi-square comparisons (Table 21). Once again, there were no significant differences between treatment conditions, with both groups tending to show an increase over time in number of cooperative programs (chi square at four weeks = .229, df = 1; at 12 weeks, chi square = .183, df = 1).

Summarizing the independent and dependent variables, the data analysis revealed two consistent trends. First, the workshop treatments were indeed significantly different in their ability to influence the participants' perception of Goal and Task Similarity, and this effect remained significant over time. Indeed, in only one of these four measures--Goal Similarity

Tab	le	21
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Contingency Table--New Joint Programs--4 and 12 Weeks

Treatment	New Progr	ams4 Wks		
Condition	Yes	No	10121	
OD	2	9	11	
Traditional	4	7	11	
	6	16	22 = n	
Corre	cted Chi-squ	are = .229 w:	ith 1 df	
Significance = .632				
	atment New Programs12 Wks			
Treatment	New Progr	ams12 Wks	Total	
Treatment Condition	New Progr Yes	ams12 Wks No	Total	
Treatment Condition OD	New Progr Yes 4	ams12 Wks No 7	Total 11	
Treatment Condition OD Traditional	New Progr Yes 4 6	<u>ams12 Wks</u> <u>No</u> 7 5	Total 11 11	
Treatment Condition OD Traditional	New Progr Yes 4 6 10	no No 7 5 12	Total 11 11 22 = n	
Treatment Condition OD Traditional Corre	New Progr Yes 4 6 10 ected Chi-squ	ams12 Wks No 7 5 12 are = .183 w:	Total 11 11 22 = n ith 1 df	

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immediately following the workshop--was there a significant effect across CMHCs, which even in this case did not overpower the significant treatment effect.

Secondly, the outcome measures were equally consistent in the opposite manner: no significant treatment effects at any period, and generally significant effects across CMHCs. (Of course, this latter tendency holds only on those nested measures where this effect could be ascertained.) Thus, it appears that the workshops were not able to create any differential effects with respect to interaction among agencies, although examination of group means and tendencies indicates that both of the workshop methodologies did result in increased interaction.

Correlational-Associative Analysis

As mentioned at the beginning of this chapter, following the experimental analysis of the independent and dependent variables, it was important to examine the relationship of other factors in this experiment to these variables. This became especially relevant because of the failure of the independent variables to explain the outcome; therefore, first of all, some of the descriptive and process variables were correlated with outcome measures. Two comments are apropos here: first, as always it is impossible to make any assumptions as to

causality when examining correlational data; nevertheless, these data may be significant as a guide to other factors which should be manipulated or controlled in further experiments of this nature. Second, it was impossible to completely cross-correlate all of the data in this study because of the different levels at which measurement took place; therefore, data collected from the contact person is only correlated with outcome measures gathered in the same way, and data collected from all respondents are likewise treated. It is also for this reason that omnibus multivariate correlational analysis strategies, such as cluster analysis (Tryon & Bailey, 1970) were not employed. However, for the data collected from all participants, aggregated organizational scores were computed, where meaningful, for the correlational analysis. Where an aggregate score would have been conceptually meaningless, no correlations were computed.

<u>Correlation between aggregated independent and</u> <u>dependent variables</u>. Much of the initial premise of this study was based upon previous findings of a high correlation between perceptions of similarity and interaction. These correlations in this study, as seen in Table 22, are moderately strong at both pretest and posttest. Surprisingly, the relationship is actually

somewhat stronger before the workshop, which indicates that other factors intervened to explain more of the variance in interaction.

	Interaction Pretest	Visits Pretest	Interaction Posttest	Visits Posttest
Goal Similarity Pretest	.469*	.513**	.267	.533**
Service Similarity Pretest	.461*	.382*	.308	.388*
Goal Similarity Posttest	.299	.331	.453*	. 397*
Service Similarity Posttest	.120	.215	.381*	.476*

Table 22

Correlation between Independent and Dependent Variables

*p < .05

Organizational characteristics correlated with outcome. As can be observed from Tables 23 and 24, very few of the organizational characteristics correlate significantly with the outcome measures, even where predicted. For example, the measure of new program innovativeness among the CMHC had only a mild nonsignificant positive relationship with increased development of new joint programs (r = .278 at 4 wks., r = .210 at 12 wks.). Among the measures of geriatric orientation of the CMHC,

Organizational Characteristics Correlated with Outcome Measures

Variable	<pre># of Planning Meetings 4 wks.</pre>	<pre># of Planning Meetings 12 wks.</pre>	New Joint Programs 4 wks.	New Joint Programs 12 wks.
Yrs. CMHC has existed	.112	.234	.085	.029
Staff Size of CMHC	139	058	.278	.015
InnovativenessNew Programs	.185	.245	.278	.210
Geriatric Admissions	185	070	.082	179
Geriatric Staff	036	167	.388*	.149
Geriatric Clients	.122	.019	.312	.332
Existence of Aging Grant	.777***	.583	.125	.194

the only significant relationship found was that between the number of geriatric staff and the new programs begun at four weeks (r = .388, p < .05). Yet even this relationship disappears at 12 weeks and actually exhibits a weak negative correlation with other outcome measures. The only strong relationship found to persist over time may easily have been predicted; that is, the correlation between whether the CMHC had received specialized aging grants and the number of planning meetings held at four weeks (r = .777, p < .01) and 12 weeks (r = .583, p < .01). Surprisingly, though, the existence of an aging grant was not at all predictive of whether any actual programs had been developed.

Table 24

	Interaction Matrix 12 wks.	Cross-Visit- ing12 wks.	Perception of Change in Interaction 12 wks.
<pre>% of Work with Elderly</pre>	170	047	.096
Satisfaction with Geriatric Programs	.218	.261	.039
Perception of Funding Available	.144	049	124
Perception of Time Available	310	241	218

Aggregated Organizational Characteristics Correlated with Aggregated Outcome Measures

Process variables correlated with outcome. None of the descriptive characteristics of the workshop itself were found to have any correlation to outcome at 4- and 12-week periods (Table 25). However, there were several significant relationships between barriers to further programming (as perceived by contact persons) and outcomes. The most significant barrier at four weeks was "Legal Problems," which correlated negatively more to outcomes at 12 weeks (r = .436, p < .05) than at four weeks (r = -.319). This may be indicative of the fact that this problem was perceived earlier than it began to take its toll. Interestingly, though, legal problems as reported at 12 weeks did not maintain their significant relationship to outcome; this may imply that the legal problems themselves diminished over the 8-week period. However, at 12-week follow-up, the only barrier which had a significant negative outcome was "Nursing Home Resistance" (r = -.435, p < .05); it may be that for some of the CMHCs the "honeymoon" period with nursing homes had ended and some of the problems in interacting had set in.

Also significant here was the total number of persons in the planning group: the more in the group, the greater the number of meetings (r = .421, p < .05) and new programs (r = .479, p < .01) at four weeks. These relationships did not appear as strong at 12 weeks,

Process Measures Correlated with Outcome

	<pre># of Planning Meetings 4 wks.</pre>	<pre># of Planning Meetings 12 wks.</pre>	New Joint Programs 4 wks.	New Joint Programs 12 wks.
Workshop Characteristics:				
Total People at Workshop	.020	.099	.270	.014
CMHC Staff at Workshop	.263	.288	212	015
Nursing Home Staf at Workshop	f 247	078	.251	.088
CMHC Administra- tors at Workshop	.170	286	072	258
Nursing Home Ad- ministrators at Workshop	236	192	.181	.133
Barriers Perceived at 4 Wks.:				
Nursing Home Resistance	271	106	080	111
CMHC Resistance	102	.165	.160	.224
Lack of Funds	086	021	.043	.061
Lack of Time	.030	085	160	.091
Lack of Interest	.008	.065	136	362
Legal Problems	319	436*	327	456*
Barriers Perceived at 12 Wks.:				
Nursing Home Resistance	 255	435*	047	436*
CMHC Resistance				

	<pre># of Planning Meetings 4 wks.</pre>	<pre># of Planning Meetings 12 wks.</pre>	New Joint Programs 4 wks.	New Joint Programs 12 wks.
Barriers Perceived at 12 Wks.: (Con't))			
Lack of Funds	111	.035	.049	
Lack of Time	102	073	.152	.063
Lack of Interest	288	072	.150	229
Legal Problems	229	226	171	196
Planning Group Characteristics:				
Total # in Group 4 wks.	.421	.206	.479*	046
Total # in Group 12 wks.	.148	.239	.413*	.308
Miscellaneous:				
Contact Person's Judgment of Prospects 04 wks.	. 528**	. 347	. 299	104
@12 wks.	.256	.353*	.054	.170

Table 25--Continued

*p < .05 ** p < .01

however, with the only significant correlation being that between the number in the group at 12 weeks and the number of new programs before this, at four weeks (r = .413, p < .05); it is possible that early success allowed the group to continue to function at a higher capacity, or vice-versa.

Finally, the contact person's optimism was correlated with outcomes; this optimism showed a significant relationship only to the number of meetings, not to the actual programs begun, and this relationship was only maintained within each time period as opposed to across periods (at four weeks, r = .528, p < .01; at 12 weeks, r = .353, p < .05).

Aggregated process variables correlated with

<u>outcome</u>. Only two process variables assessed from individuals could be meaningfully aggregated to create an organizational score; these measured the degree to which the manual was used and the amount of discussion about joint programs with staff of other agencies. Of these two, only the latter, discussion, correlated significantly, such that the greater the degree of discussion, the more likely was the organization to be interacting more (r = .659, p < .01) and to perceive itself as increasing interaction (r = .805, p < .01) (Table 26).

Table	2	6
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	Interaction Matrix	Cross- Visiting	Perception of Change in Interaction
Amount Manual Was Used	.002	125	.094
Amount of Discussion about Programming with Other Agencies	.659*	.181	.805**

Aggregated Process Characteristics Correlated with Outcome

*p < .01

Process analysis. As can be seen above, much of the data collected in this experiment were intended to shed further light on the processes involved in developing interagency interaction. The results described in this section serve as a comparison of the developmental processes in High-OD versus Low-OD situations. It is through this analysis that one may examine some of the qualitative as opposed to quantitative differences in the two treatment approaches.

The first thing that becomes obvious in a review of Table 27, which examines some organizational and workshop process variables, is that there are no significant differences between the two conditions. The workshops were equally effective in getting a commitment for

Process Comparisons between Conditions--t-tests

Variable	X OD	\overline{X} Trad.	\overline{X} Tot.	df	t	р
Commitment to Plan- ning at Workshop	1.82	1.55	1.68	20	.989	N.S.
Total # in Planning Group						
4 wks. 12 wks.	9.18 11.36	8.72 9.64	8.95 10.5	20 20	.148 .658	N.S. N.S.
Contact Person's Prospects						
4 wks 12 wks.	2.27 2.00	2.64 1.91	2.45 1.95	20 20	.647 .149	N.S. N.S.
Barriers4 Wks.:						
CMHC Resistance	1.11	1.00	1.05	20	1.06	N.S.
Nursing Home Resistance	1.78	1.40	1.58	20	1.07	N.S.
Lack of Funds	2.00	2.10	2.05	20	.250	N.S.
Lack of Time	1.67	2.00	1.84	20	1.06	N.S.
Lack of Interest	1.11	1.10	1.11	20	.075	N.S.
Legal Problems	1.22	1.40	1.32	20	.506	N.S.
Barriers10 Wks.:						
CMHC Resistance	1.00	1.00	1.00	18		
Nursing Home Resistance	1.40	1.20	1.30	18	.949	N.S.
Lack of Funds	2.00	1.80	1.90	18	.480	N.S.
Lack of Time	2.00	1.70	1.85	18	.818	N.S.
Lack of Interest	1.10	1.00	1.05	18	1.00	N.S.
Legal Problems	1.40	1.00	1.20	18	1.81	p<.10

planning from participants and in securing representatives for the planning group. In addition, the OD-oriented workshop was no more effective in overcoming barriers to further cooperation, such as resistance from both organizations, funding, time, or legal problems.

Another set of process data (Tables 28 to 33) was derived from individual responses to workshop and followup questionnaires and was analyzed in a nested analysis of variance format. As may have been predicted, and actually according to plan, the traditional workshop was judged significantly more effective in transmitting information (F = 4.21, df = 1, 150 pooled, p < .01) (Table 28). Yet there were no differences in participants' perceptions of the value of the workshops (F = 2.22, df = 1, 20) (Table 29) or the value of the manual (F = .264, df = 1, 20) (Table 30). Once again, there was significant variation across CMHCs regarding the amount of discussion in which participants took part in the weeks following the workshop (F = 2.28, df = 20, 88, p < .01) (Table 31) and in the participants' judgment of the amount of resistance the CMHC would post toward new programming (F = 1.77, df = 20, 131, p < .01) (Table 32). While not being any more optimistic about resistance, the OD participants were much more optimistic (F = 11.56, df = 1, 20, p < .005) regarding the potential for funding for developing a joint program with nursing

Table	2	8
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Source of Variation	Sum of Squares	DF	Mean Squares	F
Treatment	.969	1	.969	3.45*
CMHC's	5.619	20	.281	1.26
Subjects	28.951	130	.222	
Treatment	.969	1	.969	4.21**
Pooled CMHC-Subjects	34.57	150	.230	
••••••••••••••••••••••••••••••••••••••	Cell Mea	ns		
OD g: Trad	roup itional gro	up	1.39 1.23	
Т	otal		1.31	
* p < .05				
** p < .01				

Analysis of Variance--Participants' Rating of Amount of Information Provided at Workshop

Table 29

Analysis of Variance--Participants' Rating of Value of Workshop

Source of Variation	Sum of Squares	DF	Mean Squares	F
Treatment	.053	1	.053	2.22
CMHC's	.473	20	.024	1.34
Subjects	1.500	85	.018	
	<u>Cell Mear</u>	IS		
OD gi Tradi	coup itional grou	ıp	1.00 1.00	
.1.0	DTAL		1.00	

Analysis of Variance--Participants' Rating of Value of Manual

Source of Variation	Sum of Squares	DF	Mean Squares	F
Treatment	.000046	1	.000046	.000
CMHC's	4.61	20	.23	.739
Subjects	21.21	68	.31	
	Cell Mean	5		
OD g Trad T	roup itional group otal	þ	1.44 1.44 1.44	

Table 31

Analysis of Variance--Amount of Discussion about Programming following Workshop--12 Weeks

Source of Variation	Sum of Squares	DF	Mean Squares	न
Treatment	7.32	1	7.32	2.77
CMHC's	52.77	20	2.64	2.28*
Subjects	101.84	88	1.16	
	Cell Mean	s		
OD gi Tradi	roup itional grou	ip 2	2.36 2.88	
Тс	otal	2	2.62	

*p < .01

Analysis	of	Variance-	Participants'	Opinion	of
		CMHC	Resistance		

Source of Variation	Sum of Squares	DF	Mean Squares	F
Treatment	.468	1	.468	.264
CMHC's	35.420	20	1.771	2.312*
Subjects	100.346	131	.766	
	Cell Mean	ns		
OD group Traditional group Total			1.83 1.94 1.88	

*p < .01

Table 33

Analysis of Variance--Optimism for Funding

Source of Variation	Sum of Squares	DF	Mean Squares	F
Treatment	4.878	1	4.878	11.562*
CMHC's	8.438	20	.422	.561
Subjects	95.573	127	.753	
	Cell Mean	ns		
OD g Trad	roup itional grou	μ	2.59 2.22	
Т	otal		2.40	

homes (Table 33). This may reflect the fact that their type of workshop was much less concerned with practicalities and thus funding issues were more prominent in the traditional informational workshop.

CHAPTER IV

DISCUSSION

Before discussing the implications of this experiment, it may be helpful to briefly review some of the reasoning behind the hypotheses and subsequent design. In essence, this experiment was an attempt to interrelate the two very separate fields of organization development and interorganizational relations. From the area of organization development came the conception of interorganizational change as resulting from alterations in interpersonal attitudes, as well as the varied group exercises designed to create the atmosphere wherein these changes could occur. Organization development's weak point, however, is its failure to look clearly at the manner in which attitude changes specifically can influence behavior, especially as this relates to interorganizational as opposed to interpersonal or inter-group activity. The theory of interorganizational relations, on the contrary, examines more specifically the attitudinal and environmental aspects of interorganizational interaction, without addressing the issue of changing this interaction. Because of the failure of the change-oriented organization development
field to empirically examine the determinants of change, it was necessary to look to interorganizational relations for the concepts which could fuel an investigation. Particularly germane among these was the concept of "perception of similarity," which, while encompassing several other prevalent earlier concepts, also had been shown to be highly correlated with interorganizational interaction. For this reason, the researcher designed an organizationdevelopment style intervention, which was intended to, and indeed did, have a significant effect in altering group members' perceptions of goal and task similarity. The results indicated, however, that there were no differences between groups with high goal/task similarity and groups with lower goal/task similarity in subsequent levels of interagency interaction, which increased for both groups. In other words, the fundamental hypothesis that increasing perceptions of similarity would increase interorganizational interaction was not borne out.

Experimental Results: Implications

From the results, one could of course argue that the organizational development technology employed is essentially superfluous and that changes in interagency interaction must be brought about by some other factor. Before examining the arguments for and against organization

development raised by these data, however, it is important to consider some powerful alternative explanations.

One primary question concerns the appropriateness and relevance of attempting to operationalize and utilize a concept such as "perceived similarity" at the intervention level. While the strong correlation between similarity and interaction made it indeed attractive as a potentially manipulable variable, an experiment along these lines may succumb to the many pitfalls in attempting to relate attitude change and behavior change. Indeed, this complex relationship has often been tested, with the result that in most cases there has been found little correlation between attitudes and behavior.

The present experiment falls prey to some of the problems in attitude/behavior studies mentioned by Fishbein and Aczen (1975). Specifically, these authors argue against attempts to relate attitudes and behaviors which fail to distinguish between the attitude toward an <u>object</u> and the attitude toward a <u>behavior</u>; this latter focus is one of the two major components of an <u>intention</u>, the best predictor of behavior. In a sense, the organizational development workshop was largely oriented toward changing attitudes toward the <u>object</u> (i.e., the other organization). On the other hand, the traditional workshop was a persuasive presentation designed solely to improve attitudes about the target <u>behavior</u>, working together, and following the

reasoning of Fishbein and Aczen, may have actually been <u>more</u> directed toward changing the dependent variable of interest--interorganizational interaction--than was the organization development intervention.

The organizational development workshop, on the other hand, was directed toward the other component of intention, the "subjective norm," which was largely ignored in the didactic workshop. By subjective norm, Fishbein and Aczen mean a person's "belief that important others think he should or should not perform a given behavior" (1975, p. 401). In essence, this is the entire focus of the organization development experience, altering the group norms so that (at least some of) the individual's norms will comply. The organization development workshop, by focusing on similarities of goals and tasks, created an atmosphere of participation wherein the person came to believe that other participants, and the workshop leader, felt that interaction should occur. Thus, each condition in this experiment addressed only part of the whole issue of changing a person's behavior through a focus on "intentions."

In addition, one could take a step back and state that other externally induced changes in "subjective norms" may have caused all of the positive change in this study and were powerful enough to wash out any treatment differences. The specific changes referred to, of course,

are the Federal legislation and subsequent pressure upon community mental health centers to create programs for the aged. This explanation becomes increasingly attractive in that the sample was a group of "volunteer" CMHCs, the first 22 to respond, arguing strongly that these were organizations earliest to feel that "important others" thought that they should change.

Therefore, because of the need to be more concerned with "intention" as opposed to "attitudes" when attempting to change behavior, it may be unsound to attempt to utilize interorganizational relations concepts that are largely attitudinal or descriptive in an intervention effort. For this same reason, one ought to focus organization development activities more directly on attitudes toward the desired <u>target behaviors</u> in order to promote behavioral change.

Because each of the workshop types was equally successful, it is difficult to examine further the relative merits of organization development versus other intervention methods. Several design problems may also be contributing to this difficulty. Differential effects may have been masked by utilizing a too-short time perspective in the experiment. It could be possible that, while interaction was similar at 12 weeks, one of the conditions would have proven superior further on. Organization development proponents indeed argue that their focus on process and

underlying attitudes creates a more sound basis for interaction and, therefore, leads to longer term relationships; this may or may not be relevant but awaits empirical investigation.

The loss of the data from the nursing home representatives also represents a threat to strong conclusions from this study. One could indeed argue that the inability to look at the other groups' perceptions of similarity may have masked possible dissonance in attitudes which could have been influencing attempts at further interaction. Further investigations should examine the reciprocity of attitudes such as perceived similarity in order to shed more light on this area.

These cautions notwithstanding, it is difficult to examine the data without raising some serious questions about the merits of organization development change technology in the interorganizational field. Organization development proponents argue that organizations are groups of people and that by working with groups of people, we can make the organization more "effective." In some ways, this argument falters when applied to the interorganization scene, where external factors may be the prime motivators. This is in keeping with the work of Levine and White (1961) who saw resource interdependence, a factor largely beyond the "control" of any individual, as the prime factor in interagency linkages.

Thus, one could argue that the increases in interorganizational interaction found in this study were independent of any of the specific workshop methodologies or philosophies used. What may have been the most powerful determinant of change was simply the bringing together of the representatives of the two types of organizations. By being in the same room for a day, they were able to learn informally about their mutual needs and resources, and, as importantly, to overcome some of their previous beliefs about the other organization. This hypothesis could be tested by comparing interventions with or without face-toface contact, but it seems likely that some interaction during the intervention will beget more interorganizational interaction in the long run. The across-the-board increases in interaction found in this study strongly support this strategy.

One should also note that "perceptions of similarity" did, in fact, rise for both groups in the study, although significantly more in the organization development condition. This perceived similarity remained high for the organization development group following the workshop $(\overline{X} \text{ pretest} = 2.79; \overline{X} \text{ workshop} = 4.19)$ and, dropping slightly, at 12-week followup (\overline{X} 12 weeks = 3.74). For the traditional group, however, the increase was more evident following the workshop (\overline{X} pretest = 2.88; \overline{X} workshop = 3.48; \overline{X} 12 weeks = 3.12). It may be that "perception

of similarity" has a strong mediating influence on interaction and that the ability of the traditional workshop to initially increase these perceptions, although not as much as in the OD condition, was also the cause for change in this group. A more likely interpretation of this finding, however, is that increased perceptions of similarity are simply a correlate of an increase in the <u>intention</u> to change interorganizational behavior, as opposed to a cause.

<u>Correlational Analysis:</u> Implications

Because of the somewhat ambiguous results of the experimental portion of this study, it is especially important to examine the correlational findings as a guide to further research and interventions. One particularly relevant set of correlations is that between the independent variables (goal and task similarity) and the outcome measures of interaction, as much of the original impetus for this study derived from previous findings of high correlations between these variables. As was noted before, these factors were found to be moderately correlated, although not nearly as strongly as in the study by Tornatzky and Lounsbury (1973). Further research in interorganizational interaction, whether experimental or descriptive, ought to more fully consider this relationship for its predictive qualities. In addition, the question of whether perceptions of similarity are an essential concomitant of interaction remains to be answered.

In addition, it is important to call attention here to the regularly significant differences across the nested organizational factor revealed in this study. The occurrence and strength of these differences supports the contention that there may be some underlying factors such as organizational climate or organizational norms which are more powerful than any individual participant or treatment differences. Given this pattern of results, it would be helpful for further research to more closely examine organizational types, especially as these relate to willingness to interact and change.

Of particular interest are those descriptive characteristics of a CMHC which seemed to relate to outcome and this could provide some basis for selection of participants in future interventions of this sort. Surprisingly, two of the factors which may have been predicted to be most salient showed only mild or ambiguous results. Those CMHCs with larger staff assigned to geriatrics were able to move farther in programming at first, but this discrepancy disappeared between the 4and 12-week measurements. Along with this, CMHCs with special funds provided for aging were more likely to have had more planning meetings but no more likely to

have started more actual programs after 12 weeks. This may imply that the funding for programs would be more effective if it followed more "voluntary," self-motivated efforts. Nevertheless, it may also be true that the tendency of funded agencies to meet more frequently (r = .583, p < .01 at 12 weeks) leads to stronger programs which would be evident in later measurements. These findings lend credence to strategies for change which rely upon motivators other than funding or staff; further research should look more closely at the effects of different incentives for change, paying special attention to when these incentives are both offered and actually provided.

Additional analyses examined some of the process issues in starting new interorganizational linkages as these related to outcome. Particularly important here were the types of barriers perceived by the CMHC contact persons and whether these barriers actually impeded results. One barrier which did seem to hinder results was that of legal issues; the data indicate that a perception of these issues as being strong barriers at the 4-week testing corresponded with weaker results at 12 weeks. Surprisingly, though, the legal problems were not as significant at this 12-week point. One may infer different possibilities from this. First, the legal problems may present themselves early, may take a little longer to solve (thus showing us poorer results at 12 weeks), and then may disappear as issues because they were addressed directly. Alternatively, the legal problems may be evidence of an initial cautiousness on the part of both parties and, in essence, represent an artificial barrier emphasized until other, more fundamental, issues such as trust, resistance, etc., are resolved.

A barrier which seems to operate in the opposite manner for CMHC staff is "nursing home resistance." This barrier correlated negatively with outcome only at 12 weeks; the greater the resistance perceived by the CMHC staff contact, the less the actual interactions had occurred (r = .435, p < .05). It is tempting to attribute some degree of causality here and infer that the resistance of the nursing home staff was impeding positive results. There may just as likely be a tendency for the CMHC staff to use this supposed "resistance" as an excuse or explanation for other problems which could be in or out of their control. A complete set of data from the nursing homes would have enabled a more precise analysis of this issue of resistance, as the CMHC staff did not feel that their own resistance was a barrier at all; personal experience would tend to disprove this.

Furthermore, other barriers did not relate to outcome as may have been expected. These include lack of funds and lack of time to interact; once again it is possible that CMHCs selected themselves into this study because of their stronger motivation to develop joint programs with nursing homes and that a nonvolunteer sample would have shown different characteristics here. It is also not improbable that responses to these items were strongly biased by the CMHC staff's need to seem motivated and involved and that either a full set of responses from nursing homes or an actual behavioral measure of time involved would have better elucidated these issues.

The results of this experiment also revealed a significant correlation between the contact person's optimism about joint programs and the number of planning meetings held (r = .528, p < .01 at 4 weeks; r = .353, p < .05 at 12 weeks). There was little relationship, however, between optimism and actual amount of joint programming; this may not be as meaningful because, in many ways, planning meetings are significant outcomes in a 12-week time frame. This finding has definite implications for the role of individuals versus groups in a change effort such as this, for there was also found to be a significant relationship between the number in the planning group and the degree of programming created.

One may infer that the energy and optimism of an individual is indeed needed to insure that meetings and tasks get accomplished while the support of a group is needed for the actual sanction to work together. The change agent must not ignore, then, the cultivation of an individual to spearhead and coordinate the change effort in working with a group.

The need for someone to pull together meetings, etc., is backed up by another, predictable finding: the greater the actual amount of discussion between representatives of the separate organizations, the more likely were they to perceive themselves as working together (r = .805, p < .01) and to actually be working together more (r = .659, p < .01). The critical inference here relates to the need for actual face-toface contact in promoting interorganizational interaction and, further, the need for someone to advocate for and coordinate this contact.

A separate area of data analysis concerned any possible differences between the organization development and traditional workshops in regard to process issues. Significant differences here would be especially meaningful in the light of the similarity of the two conditions with regard to outcome. Once again, however, there were no significant differences between the conditions in their ability to overcome barriers, to obtain representatives for a planning group, and to get a commitment for further meetings. The organization development workshop participants were found to be more optimistic immediately following the workshop about the potential for funding; this is most likely because funding and programmatic issues were down-played in this condition and the "high-similarity" atmosphere was one of optimism. Corroborating this explanation is the fact that the traditional workshop was judged to be much more informational (F = 4.21, df = 1,150, p < .05).

Summary and Future Directions

As can be seen from the previous discussion, this experiment actually raises more questions than it answers. One initial direction, which needs further testing, concerns the usefulness of organization development techniques in promoting interorganizational change. In fact, the results suggest that a traditional, knowledgeoriented workshop was equally successful as a processoriented organization development experience. Following from this, one might imply that organization development techniques, while conceptually sound on paper and in theory, are in practice no more valid than other approaches.

Fortunately for organization development proponents, this conclusion awaits further testing. A more sophisticated examination of this issue should make the

above-mentioned distinction between "attitudes toward objects," "attitudes toward behaviors," "subjective norms," and "intentions" (Fishbein & Aczen, 1975). Separate intervention techniques must carefully specify their objectives in these terms; it is easy to conceive of a behavior/intention-oriented intervention as being a more successful effort. An intervention of this sort would utilize some of the organization development methods but orient them more toward the direct benefits and outcomes of interaction. Thus, while the organizational development exercises in this study focused on process issues such as "similarity," a future set of exercises might just as fully look at "perceived benefits of interaction," "potential barriers," and, finally, at the action steps needed for further linkages.

Additional attention in promoting interorganizational relations must be paid to external factors influencing the "subjective norms." Assuming of course that these external pressures are not mandatory laws, one should attempt to measure the degree to which participant organizations are influenced by and feel a need to adhere to these "subjective norms." Equally important here is the issue of who the "significant others" are who influence the perception of these norms. While some organizations may be influenced greatly by governmental pressures, it may just as likely be the influence

of the administrator or even a strong contact person which leads to behavior change. Thus, while further research might attempt to manipulate the type of attitude change created, it should not be blind to the effects of external forces upon the change of participants. Although this is not an easily controlled factor, an effort to avoid the use of totally volunteer organizations would eliminate much of the confounding nature of these effects.

An additional problem in interorganizational intervention is the specification of the target organization. Because, in this case, it was necessary both for fiscal and practical reasons to make initial contacts with the CMHCs, the nursing homes were involved largely as latecomers. This led to even greater difficulties in the willingness of these organizations to return questionnaires and in other ways take part in the data collection process. Of course, the result was that this whole bloc of organizations had to be eliminated from the data analysis and what was left was essentially a one-way look at a two-way phenomenon.

More effort should also be made to establish true behavioral indicators of interaction and other outcome measures. This is extremely difficult given the usual need to go far beyond one's own community to establish adequate samples but would do much to

eliminate the multiple problems of self-report, interviews, and paper-and-pencil tests.

There was also no attempt made in this experiment to control for or measure effects of the workshop leader. Economic realities necessitated that all workshops be conducted by the same person; while the difference in levels of the independent variables attest to the actual differences between workshops, there is no way to determine how much the changes in outcome measures were dependent upon the trainer's skills and personality. Further research into creating interorganizational linkages should carefully consider this factor.

Finally, one comment must be made concerning the study of interorganizational interaction. Much effort is currently being expended on descriptive, "theory-building" research in the interorganizational field, including human service agencies. Because of the need of our country to continue to address pressing social problems in an era of ever dwindling resources, research in this area is becoming increasingly needed. However, it is the belief of this author that until researchers finally begin to actually manipulate variables in an experimental manner, we will know little about the actual methods of increasing positive interorganizational interaction. Experimental research of this sort is costly, time-consuming, and difficult; it also can lead the way toward a more effective, efficient human service delivery system. APPENDICES

APPENDIX A

DESCRIPTION OF THE ST. LAWRENCE CMHC

NURSING HOME PROJECT

APPENDIX A

DESCRIPTION OF THE ST. LAWRENCE CMHC NURSING HOME PROJECT

NURSING HOME TRAINING AND CONSULTATION PROJECT ST. LAWRENCE HOSPITAL - COMMUNITY MENTAL HEALTH CENTER

1201 West Oakland, Lansing, Michigan 43915

- GOALS: To improve the psychosocial care of the elderly residents of long-term care facilities through:
 - 1) providing information on the mental health processes of aging:
 - providing information on the treatment of the problems of patients;
 - helping the nursing home staff evaluate and design mental health treatment plans for individual residents;
 - encouraging the treatment of problem patients within the home in order to eliminate transfer to a mental health facility;
 - 5) demonstrating therapeutic use of activities;
 - 6) developing communication skills of staff to psychosocial needs of patients.
- METHODS: 1) Provide information and skills STAFF TRAINING PROGRAM.
 - 2) Assist the staff in setting up mental health care plans for individual residents - CASE CONSULTATION.
 - 3) Improve diversional activity options and more appropriately plan an individual's involvement ACTIVITY PROGRAM CONSULTATION.
 - 4) Develop a group of staff within each home who work together on program changes CORE GROUP DEVELOPMENT.
- FUNDING: The project was originally funded by a one year research grant through the Michigan Association for Regional Medical Programs.

It is now an ongoing program receiving funds from the local Community Mental Health Board.

AVAILABILITY OF SERVICES:

Services are available to any long-term care facility for the elderly in Ingham, Eaton or Clinton counties. Contractual agreements define specifically the responsibilities and committments of the nursing home in order to receive services, these include allocation of staff time, space, resources, etc..

STAFF TRAINING PROGRAM

50ALS: To provide the staff with a basic knowledge of the mental health needs of the institutionalized elderly and some methods, approaches and tools to use in working to meet the needs of these people.

To provide the staff with an understanding of the causes and some of the possible solutions to behavior problems in their patients.

COMPOSITION: All staff of nursing home - administrative, nursing, and ancillary at all levels. Staff training occurs in the nursing home, on a weekly basis.

OUTLINE OF TOPICS:

- INTRODUCTION TO MENTAL HEALTH AND THE AGED: an approach to understanding the mental health of the elderly through a framework of the unique losses that occur with age and institutionalization; possible ways to alleviate or substitute for some of these major losses; problem behaviors cause, meaning, and treatment;
- ORGANIC BRAIN SYNDROME & CONFUSION: the causes and symptoms of both acute and chronic brain syndromes and a look at techniques for stabilization and remediation; other causes of "confusion";
- 3) DEPRESSION: the picture of the depressed patient; individual and programmatic approaches to handling depression; depression and confusion;
- 4) MEDICATION: the uses and abuses of psychotherapeutic drugs with the elderly nursing home patient; recognizing possible side effects;
- 5) ACTIVITIES AND NURSING: necessity for meaningful activity for the geriatric patient; methods of assessing the activity needs of an individual; an exploration of the ways nursing staff can provide "activity" during regular nursing care; group vs. individual activity;
- 6) ACTIVITY PROGRAMS: the uses of therapeutic activity programming; a discussion of the possible integration and cooperation of nursing staff into the activity program; activity vs. busywork; beyond crafts; competition, education, etc.;
- 7) THE CASE CONFERENCE: methods for assessing the mental health needs and problems of an individual patient; how to set up a case conference to plan for these needs; how to evaluate progress;
- SPECIAL PROBLEMS: dependency, hypochondria, aggression, and any other concerns voiced by the staff.

CASE CONSULTATION SERVICES OF THE NURSING HOME PROJECT

WHAT ARE MENTAL HEALTH CONSULTATION SERVICES?

The case consultation service offered by the Nursing Home Training and Consultation Project at St. Lawrence CMHC is designed to assist nursing home staff in evaluating and working with patients exhibiting emotional or behavioral problems:

- 1) CMHC staff evaluate the patient and his/her problems through interviews, discussion with staff, review of records, etc..
- 2) CMHC and nursing home staff meet to discuss treatment recommendations and to develop a treatment plan.
- 3) Nursing home staff work with the patient under the guidelines of this treatment plan.
- CIHC staff return for follow-up evaluation and meeting to plan any changes in the treatment plan and to help revise recommendations.

HHO DOES THE CONSULTATION?

The staff of the Nursing Home Project includes:

Jon York, M.A., Psychologist, Project Director Mary Ann Smith, O.T.R., Occupational Therapist Consultant-Trainer Diane Charron, R.N., Psychiatric Nurse Consultant-Trainer

MHAT KIND OF PATIENTS BENEFIT MOST?

Our experience has shown that most dramatic changes can be seen if the patient is referred early in the process of developing problems; in other words, new admissions, or patients who have developed new problems. Consultation can also help, however, with more long-term problems, especially in helping staff understand and deal with the problem behaviors.

HOW IS CONSULTATION ARRANGED?

There should be consensus among staff concerning which patients to refer. One staff member who works closely with the patient (nurse or aide) takes responsibility for coordinating the consultation. This staff member should complete a "Consultation Request Form", and mail it to:

> Mursing Home Project St. Lawrence Hospital Community Mental Health Center 1201 West Oakland Lansing, Michigan 48915

or call: 372-7900, ext. 236

We will schedule a consultation visit as soon as possible, usually within a week.

ACTIVITY FROGRAM CONSULTATION

GOALS: To enhance the staff's awareness that activity is therapeutic; that self-motivated people need a variety of opnortunities but minimal direction or assistance whereas non-motivated people need encouragement, direction and often physical assistance.

> To acquaint the staff, especially the activity director, with methods of assessing residents, adapting activities, planning balanced programs and communicating observations to other staff members.

- PURPOSE: The function of activity consultation is twofold. While assistance is given to the director to provide a more appropriate program, the staff is simultaneously learning the benefits of activities and ways of providing activity while carrying out nursing care responsibilities.
- BEMEFITS OF ACTIVITIES:
 - PHYSICAL Provide good circulation and natural tiredness; maintain muscle strength and joint range of motion and possibly remediate lost skills.
 - SOCIAL increase interaction with others in cooperative and/or competitive way; provide opportunities for reenacting lost roles and possibly developing friendships.
 - MENTAL stimulate interest to stay alert, to maintain attention span, to follow directions and to learn new things.
 - EMOTIONAL provide an opportunity to feel and express emotions that may be forgetten; anger of losing, joy of winning or sharing, competitiveness, frustration, and others.

PROCESS

- 1. Lectures to all staff on the therapeutic use of activities, on how to assess residents' abilities and needs and how to communicate that information.
- 2. Consultation, discussion, and handouts designed for the activity director (but available to all) on such facets as: craft activities exercise groups discussion topics volunteers program planning motivation techniques reality orientation record keeping
- 3. Demonstration of activities with residents from the particular home.

CORE GROUP DEVELOPMENT

PURPOSE: The major function of the core group is to provide a mechanism which translates information presented in the staff training into planned and coordinated action. Many types of inservice training transmit voluminous amounts of material but fall short in actually creating a change in staff behavior. The core group development takes the information past a discussion phase to the point of determining "what can we, as nursing home staff, do in this particular place?" Another purpose is to increase staff commitment to taking some action by involving staff of different levels and disciplines in the planning and decision making. The final purpose is to provide homes with a cohensive and committed group of nursing home staff who are capable of working together in planning after the CMHC team leaves the home.

PROCEDURE:

PRE-PLANNING:

- 1) Nursing Home selects a group of approximately eight to ten staff representing a cross section of staff levels and disciplines; often the top administrator chooses not to attend (to avoid impeding free discussion) but must be in support.
- Nursing Home and Project staff agree on a <u>regular</u> time and place for core group meetings; at least 2 times per week for the first 10 weeks. Meeting time is renegotiated after that.

NURSING HOME STAFF'S ROLE IN CORE GROUP DEVELOPMENT:

- 1) Meet with Project staff to acquaint members to each other and discuss purpose of the core group.
- 2) Share ideas about what is needed in this nursing home to improve psychosocial care.
- 3) Assess needs raised with respect to priority and feasibility.
- 4) Select an area of need or problem to work on.
- 5) List different methods to meet the particular needs that were selected.
- 6) Determine resources needed and available to solve the problem such as time, money, people, and materials.
- 7) Select feasible implementation methods to use for solving the problem.
- 8) Assign tasks that need to be done.
- 9) Evaluate what progress has been done, evaluate how action taken affected staff, and how action affected patients; make necessary adjustments.
- 10) Determine other needs of the nursing home that could be worked on by staff. (Go back to step 2.)

ROLE OF PROJECT STAFF:

- 1) Initiate discussion and goal direction for core group at the first few meetings.
- Help organize ideas raised by nursing home staff, and provide problemsolving framework.
- 3) Relate how ideas raised pertain to information presented in the staff training sessions.
- 4) Monitor the group to keep to the task at hand.
- 5) Provide expertise in areas requested by the nursing home staff.

APPENDIX B

CONTACT LETTER, HEW REGION V OFFICE

APPENDIX B

CONTACT LETTER, HEW REGION V OFFICE

Dear (CMHC Director):

Reflecting a strong belief in the necessity of mental health liason and followup services for the elderly, I would like to introduce to you Project Link-Age. Project Link-Age is a Regional Office ADAMHA funded program which will assist you in beginning to meet the requirements of services to the aging mandated by Public Law 94-63.

As you will note from the attached letter and brochure, staff from Project Link-Age will be contacting you soon to make further arrangements for your participation.

I urge your cooperation and remain confident that you will find this to be a valuable experience.

Sincerely yours,

Michael Houlihan, Chief ADAMHA Branch

MH/j

enc.

APPENDIX C

CONTACT LETTER, PROJECT LINK-AGE

APPENDIX C

CONTACT LETTER, PROJECT LINK-AGE



AN HEW DEMONSTRATION PROJECT

St. Lawrence Hospital CMHC • 1201 West Oakland Lansing, Michigan 48915 • Phone 517/372-7900

December 7, 1976

:

Dear

Project Link-Age is an HEW (Region V) Demonstration Project designed to assist community mental health centers in developing liaison programs with geriatric care facilities such as nursing homes. CMHC, as a Federally assisted center, qualifies as one of the target centers for Project Link-Age's efforts.

We would like to solicit your participation in this project at this time. If you agree to take part, we will offer you either a workshop or a manual designed to assist your staff in working with the elderly and nursing homes. In addition, we will offer follow-up consultation visits and telephone calls as needed by your staff in their programming efforts. In return, we will ask that some of your staff complete several short questionnaires in order to assist us in the evaluation of the project and that these staff take part in our workshop or consultation visits.

Please indicate your willingness to be a part of Project Link-Age by completing and returning to us the enclosed "Staff Contact Form." In order to do this, you must simply:

- A) Designate one member of your staff as a future contact person for Project Link-Age to assist us in scheduling, data collection, etc. Indicate the name of this person on the attached form.
- B) Designate seven other members of your staff to be involved in the future with Project Link-Age. Indicate their names also on the contact form, and distribute one copy of the enclosed brochure to each.

Page 2

These designees should include, at the minimum:

- (1) consultation and education director/staff
- (2) geriatric program director/staff
- (3) aftercare or placement director/staff
- (4) any others you feel should be involved
- C) Sign and return this form in the postage-paid envelope.

Thank you very much for your cooperation; we are looking forward to being able to work with ______ in the coming months, and to assist you in this crucial area of geriatric programming.

Sincerely,

Jonathan L. York Director Project Link-Age

JLY/jn

Enclosures

APPENDIX D

STAFF CONTACT FORM

APPENDIX D

STAFF CONTACT FORM

STAFF CONTACT FORM - See Letter for Instructions

A.	DESIGNATED CONTACT PERSON:				
	NAME	STAFF POSITION	PLEASE SPECIFY DISCIPLINE (R.N., M.S.W., etc.)		
в.	OTHER STAFF TO BE IN	VOLVED:			
	NAME	STAFF POSITION	PLEASE SPECIFY DISCIPLINE (R.N., M.S.W., etc.)		
1.					
2.					
3.					
4.					
5.					
6.					
7.					
с.	AGREEMENT I wish to have the above members of my staff participate in the efforts of Project Link-Age, HEW Region V, including a one-day workshop and data collection, as outlined in the attached letters and brochure.				
	SIGNATURE:				
	CMHC:				
	ADDRESS:				
	CITY, STATE, ZIP:				
	TELEPHONE NUMBER:				

APPENDIX E

TIMETABLE AND TASK CHECKLIST

APPENDIX E

TIMETABLE AND TASK CHECKLIST

Condition:	Workshop		
CMHC Name			Code #
Address			
Director			
Telephone			Contact Person:
<u>Step #</u>	Time Span	<u>Write-in dates:</u>	Task
١			Contact letters sent
2	+10 days		<pre>call to director if response not received (Protocol #1)</pre>
3	at receipt of Contact Form		<pre>call to Contact Person (Protocol #2)</pre>
4	l day after Step #3		<pre>letter to contact person verifying call (Protocol #3) with pretest forms</pre>
	CMHC staff names		Position

Task Checklist Page 2

Step #	<u>Time Span</u>	<u>Write-in dates:</u>	Task
5	10 days after Step #3		call Contact person to get list of names & schedule (Protocol #4)
	date workshop scheduled		
	Nursing Home	Address	Administrators Name

6	l day after Step #5	send out pretest forms & brochures to nursing homes (Protocol #5)
		(Protocol #6)
7	2 weeks after Step #6	call contact person if forms are not yet received (Protocol #7)
8	5 days before workshop	call contact person to verify arrangements (Protocol #8)
9	4 weeks post- workshop	First followup call with Contact Person
10	ll weeks post- workshop	Send out followup forms to nursing homes (Protocol #9) and Contact Person (Protocol #10)

Task Checklist Page 3

Step #	<u>Time Span</u>	Write-in dates:	Task
11	12 weeks post workshop		Second followup call with Contact Person
12	3 weeks after Step 10		Call Contact Person to send forms back (Protocol #11)

APPENDIX F

INITIAL ASSESSMENT FORM


APPENDIX F INITIAL ASSESSMENT FORM

Name 4 Discipline 4 Name of CMHC		Project Link-Age CODE # CMHC Preliminary Information Questionnaire T	-3
Discipline	Nan	ne	
Name of CMHC	Dis	scipline	
Date	Nan	ne of CMHC	4
GENERAL BACKGROUND INFORMATION 5-6 1. How long has your CMHC been in existence? 5-6 2. What is the size of the staff at your central CMHC location? Please express as a FTE* number. 7-9 3. Are there any satellite or extension centers? 7-9 3. Are there any satellite or extension centers? 10 If yes, please complete the following: 10 Satellite name	Dat	te	
1. How long has your CMHC been in existence? 5-6 2. What is the size of the staff at your central CMHC location? Please express as a FTE* number. 7-9 3. Are there any satellite or extension centers? 10 If yes, please complete the following: Satellite name	GEN	IERAL BACKGROUND INFORMATION	
2. What is the size of the staff at your central CMHC location? Please express as a FTE* number. 7-9 3. Are there any satellite or extension centers? 76 Yes 10 If yes, please complete the following: Satellite name 11-12 Type of Staff (FTE) 11-12 Type of Service 13 Satellite name Number of Staff (FTE) 14-15 Type of Service 16 Satellite name Number of Staff (FTE) 16 Satellite name 16 Satellite name 17-18 Type of Service 19	1.	How long has your CMHC been in existence?	5-6
3. Are there any satellite or extension centers? Yes_1 No_2 10 If yes, please complete the following: 10 Satellite name	2.	What is the size of the staff at your central CMHC location? Please express as a FTE* number.	7-9
Yes 1 No 2 If yes, please complete the following: 5 Satellite name 11-12 Number of Staff (FTE) 11-12 Type of Service 13 Satellite name 14-15 Number of Staff (FTE) 16 Satellite name 16 Satellite name 17-18 Type of Service 19	3.	Are there any satellite or extension centers?	
If yes, please complete the following: Satellite name		Yes1 No2	10
Satellite name		If yes, please complete the following:	
Number of Staff (FTE) 11-12 Type of Service 13 Satellite name 14-15 Number of Staff (FTE) 14-15 Type of Service 16 Satellite name 16 Satellite name 17-18 Type of Service 19		Satellite name	
Type of Service		Number of Staff (FTE)	11-12
Satellite name 14-15 Number of Staff (FTE) 16 Satellite name		Type of Service	13
Number of Staff (FTE) 14-15 Type of Service 16 Satellite name		Satellite name	
Type of Service16 Satellite name Number of Staff (FTE)17-18 Type of Service19		Number of Staff (FTE)	14-15
Satellite name Number of Staff (FTE) 17-18 Type of Service 19		Type of Service	16
Number of Staff (FTE) 17-18 Type of Service 19		Satellite name	
Type of Service19		Number of Staff (FTE)	17-18
		Type of Service	19

*FTE = Full time equivalent. e.g. 2 parttime staff members equal 1 FTE staff member.

4. Does your CMHC have any special Federal or state grants or contracts?

If yes, please describe briefly below:
Name of program
Funding source
Grant size
Purpose
Duration
Name of Program
Funding source
Grant size
Purpose
Duration
Name of program
Funding source
Grant size
Purpose
Duration

6. Is your catchment area population predominately rural or urban?

		rural1 urban2 equally both3	37
SPE	CIFI	C PROGRAM INFORMATION	
7.	Inp	atient Psychiatric Treatment	
	a)	Do you have an inpatient psychiatric unit?	
		Yes1 No2	38
		If yes, how many beds?	39-40
	b)	Are there any beds set aside only for older persons?	
		Yes1 No2	41
		If yes, how many beds?	42-43
	c)	Approximately what percent of total yearly inpatient admissions is made up of people over 65 years of age?	
		%	44-45
8.	Out	patient Therapy	
	a)	How many staff members (FTE) work in your outpatient unit?	46-47
	b)	Are any staff members specifically designated to work with older people?	
		Yes <u>1</u> No <u>2</u>	48
		If yes, how many?	49
	c)	Approximately what percent of your annual outpatient clients are over 65 years of age?	

% 50-51

9. Emergency Services a) How many staff members (FTE) work in emergency psychiatric services? 52 - 53b) Approximately what percent of your emergency service clients are over 65 years of age? 54-55 % 10. Consultation and Education Program a) How many staff members (FTE) work in consultation and education? 56-57 b) Your consultation and education program accounts for what percent of your total CMHC budget. % 58-59 c) Please list briefly the major types of consultation and education activities. 60-61 d) What percent of consultation and education staff time is spent on providing services to the elderly or to agencies serving the elderly? % 62-63 11. Specific Geriatric Programs a) Do you have any specific geriatric programs? 64 Yes 1 2 No If yes, please describe below Program name_____ Number of Staff (FTE)_____ 65 Purpose _____ 66

N.

b)

Program name	
Number of Staff (FTE)	67
Purpose	68
Do you have any programs not mentioned above which involve nursing homes?	

If yes, please describe briefly

APPENDIX G

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GOAL/TASK SIMILARITY QUESTIONNAIRE

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GOAL/TASK SIMILARITY QUESTIONNAIRE

CODE #

On this question, we would like you to evaluate how similar (or different) the <u>general</u> <u>goals</u> of your organization are in comparison with those of the other organizations <u>listed</u>. Place a check mark (*⁽⁾) in the box which corresponds to the degree of similarity of <u>your organization's general goals</u> with those of the organization in the left-hand columm. Ignore the row with your agency's name in it. Directions:

	Simila	rity of Ment	al Health Se	rvices to Ge	riatric Pati	ents
Organization	Very Different	Different	Slinhtly Different	Slightly Similar	Similar	Very Similar
11						
18						
19						
20						
12						
22						
23						
24						
25						
26						
27		2	e	4	2	Q

On this question, we would like you to evaluate how similar (or different) the specific mental health services provided to generative patients in your agency are in comparison with those of the other organizations listed. Place a check mark (\prime) in the box which corresponds to the degree of similarily of your services to geniatric patients with the mental health services to geniatric patients provided by agencies in the left-hand column.

Directions:

APPENDIX H

100 C 100

INTERORGANIZATIONAL INTERACTION QUESTIONNAIRE

		10 or more									
		6	σ	6	6	6	6	6	6	6	6
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	er mont	~	~	7	7	7	~	~	~	~	~
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row with yo	agency										

APPENDIX H INTERORGANIZATIONAL INTERACTION QUESTIONNAIRE How often do you visit or go into each of these other agencies or do they visit your agency?

<u>Circle</u> the approximate total number of visits of any kind per month for each agency. Ignore the

. CODE #

Ways of Interacting

On this question, we would like to ascertain the degree of interaction that goes on between your agency and other agencies in the community. On the left is a list of organizations. On the top we have listed a number of ways that your organization could be interacting with these other organizations. For each of the organizations in the column on the left, please place a check mark (\prime) in the box or boxes that apply to the type(s) of contact your organization has with that agency. Please check <u>all</u> that apply.

Directions:

L

Below are some questions about the workshop participants and the working situations in your CMHC. Please answer each question by placing a check (\checkmark) after the appropriate answer or by writing the answer in the space provided. This information will be used for our research purposes only and will be kept in strictest confidence. 1. How long have you worked at this CMHC? less than one year 1 1-3 years 2 4 4-6 years 3 7-9 years 10 or more years 5 2. What is your highest educational level? some high school 1 high school graduate 2 5 some college college graduate 4 Masters 5 Doctorate (Ph.D., M.D.) 6 3. What is your age? 6-7 4. What percent of your work is directly involved in working with elderly people? 0% 1 1-25% 2 3 8 26-50% 4 51-75% 76-99% 5 100% 6

5. Have you personally ever tried to start a new program?

6. How satisfied are you with your CMHC's present effort to work with older people?

very satisfied 1	
satisfied 2	
somewhat satisfied 3	10
dissatisfied 4	
very dissatisfied 5	

TREATMENT CONDITION EVALUATION

APPENDIX I

APPENDIX I

TREATMENT CONDITION EVALUATION

PROJECT LINK-AGE CODE # 1-3

Workshop Evaluation-CMHC Personnel

Listed below are the agencies which participated in the Project Link-Age Workshop three months ago. Please place a check mark () in the box that indicates how much discussion you have had with representatives from each agency concerning the development of programs with nursing homes since the workshop. Ignore the row with your agency's name.

Name	None	Little	Some	Much	A Great Deal
49	۱	2	3	4	Ę
50					
51					
52					
53					
54					
55					
56					
57			ļ		
58		 	 		
59					
60					_
61					
62					
63				ļ	
64			ļ	ļ	
65					_
66				ļ	
67					_
68			ļ	 	
69					_
70	L			<u> </u>	

Amount of Discussion about Programming

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PROJECT LINK-AGE Workshop Evaluation-CMHC Personnel Page 2

7. Have you ever heard about the Nursing Home Training & Consultation Project at St. Lawrence CMHC before this workshop?

If yes, in which way(s)?

read the brochure 1 from a fellow worker 2 read an article about it 3 other, please specify 4

8. How were you selected to be a workshop participant?

volunteered 1 elected 2 appointed, assigned, designated 3 other, please specify 4

9. How effective was the workshop in providing information about the ways CMHC's and nursing homes can work together?

very effective 1 moderately effective 2 neither effective nor ineffective 3 ineffective 4 very ineffective 5

10. The CMHC would offer little resistence to the initiation of a program with nursing homes.

strongly agree____l agree____2 neither agree nor disagree____3 disagree____4 strongly disagree____5

11. Necessary facilities and funds <u>could</u> be made available for implementing a program like the Nursing Home Training & Consultation Project.

> strongly agree 1 agree 2 neither agree nor disagree 3 disagree 4 strongly disagree 5

15

13

12

14

PROJECT LINK-AGE Workshop Evaluation-CMHC Personnel Page 3

12. The staff I work with could be given time to work on a program like the Nursing Home Training & Consultation Project.

strongly agree 1 agree 2 neither agree nor disagree 3 disagree 4 strongly disagree 5

13. I enjoyed the workshop today.

strongly agree_____ agree_____ neither agree nor disagree_____ disagree_____ strongly disagree_____

14. I met people from nursing homes at the workshop today who would be helpful in starting a program like the Nursing Home Training & Consultation Project.

 $\frac{1}{2}$

3

4 5

strongly agree 1 agree 2 neither agree nor disagree 3 disagree 4 strongly disagree 5

15. I understand more about nursing homes after the workshop today.

strongly agree 1 agree 2 neither agree nor disagree 3 disagree 4 strongly disagree 5

20

136

18

17

APPENDIX J

OUTCOME/PROCESS INTERVIEW

APPENDIX J

OUTCOME/PROCESS INTERVIEW

Outcome/Process Interview

Respondent	Called by:
Смнс1-3	Date of Workshop/Manual
Date of Interview	Interview # 1 2

This is ______. I am calling from Project Link-Age in Lansing, Michigan. As you remember, we promised to call you at regular intervals after the original workshop (Mailing of the Manual) to look at the present status of programming with nursing homes in your CMHC and to give you any further suggestions needed. First I'd like to ask you some questions to see how things are going now.

1. Have any people gotten together to discuss nursing home programming?

Yes____1 (go on to #2) No____2 (skip to #6)

2. Who is in this group? Please give me their names and the agency they represent.

CMHC/NH

4

total persons - 5 total agencies - 6 PROJECT LINK-AGE Outcome/Process Interview Page 2

7. Has your CMHC begun any new contacts with nursing homes?

8. If yes, please explain:

9. In working toward programming with nursing homes, which of the following do you consider the biggest obstacles? (administer to all respondents)

For each of these I read tell me whether it is a

	no obstacle	minor obstacle	major obstacle
a) resistance from CMHC administration .			
b) resistance from nursing homes		_	
c) not enough money			
d) not enough time			
e) our staff doesn't want to			
f) no need seen here			
g) legal problems			
h) no planning group			
i) no staff skill in this			

10. Are there any other reasons you have not moved ahead that you can think of? 21

11. Has your CMHC started any new geriatric programs other than working with nursing homes since the time of our first contact on _____? (Date of lst contact)

11

10

PROJECT LINK-AGE Outcome/Process Interview Page 3

12. What are these new programs? Funding?

program - 23

funding - 24

13. What do you think your future prospects are for starting co-operative 25 programs with nursing homes?

Answer any questions they may have or respond to issues raised above, then promise date of next call.

14. (First call only) Thank you, I will call you next on (Date of second call)

REFERENCES

REFERENCES

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