This is to certify that the

thesis entitled

EFFECTS OF SITE VISITS ON
INNOVATION ADOPTION

presented by

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has been accepted towards fulfillment
of the requirements for

Ph.D. degree in Psychology

Major professor

Date July 12, 1979

EFFECTS OF SITE VISITS ON INNOVATION ADOPTION

By

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A DISSERTATION

Submitted to
Mighigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Department of Psychology

1979

ABSTRACT

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INNOVATION ADOPTION

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While a number of solutions to various social problems have been developed and tested, there still remains the difficulty of finding ways to increase the adoption and implementation of such solutions. This difficulty is shown to have two central components, individual and organizational resistance to change. One technique that might reduce resistance from both of these sources is a visit to the site of an innovation.

An experiment was performed to test the effects of such a visit on innovation adoption. The context of the experiment was an effort to disseminate the Community Lodge, an innovative residential treatment program for chronic mental patients. The target of the dissemination effort was a national sample of state hospitals. Twenty-four state hospitals were randomly assigned to either experimental or control conditions. Hospitals in the control condition received a workshop on the Lodge and further consultation assistance. Hospitals in the experimental condition sent one staff member on a site visit to an exemplary Lodge in addition to receiving the workshop and consultation assistance.

The results of the experiment indicated that the Site Visit intervention had significant, but rather weak effects in increasing advocacy for the Lodge, decreasing uncertainty about the Lodge, and increasing boundary spanning. There was also an indication that the Site Visit had a weak impact on adoption of the program. A cluster analysis of the data indicated that two clusters of variables, discussion about the program and attitude-certainty about the program, were both related to change, and that high scores on both were necessary, but not sufficient conditions for change to occur.

It was concluded that a Site Visit as provided in the context of this experiment has only minimal effect. Some suggestions for increasing the impact of a site visit are to include additional interventions and to strengthen the components of the visit itself. Tailoring the intervention based on a number of organizational factors is also suggested.

For all of those people

still in the institutions and boarding homes

ACKNOWLEDGEMENTS

As is often the case, a very large number of people helped in a lot of ways to make this research possible. Naturally some people helped more than others. First and foremost among these was my chairman, advisor, and friend, Lou Tornatzky. Lou made this happen in so many ways from beginning to end. This simply wouldn't be here had it not been for his encouragement and advise. Thanks, Lou!

Particular thanks must go to Dorothy Berger and the staff and patients of the Fairweather program at Anoka State Hospital, and the staff and Lodge members of Tasks Unlimited, where the site visits took place. They were kind enough to chauffeur site visitors around, to have their privacy invaded, and to put up with numbers of site visitors for days at a time. That all of the site visits went well is a testament to their skill and organizational ability, not to mention good humor.

The members of my dissertation committee, Bill Fairweather, Bill Davidson, and Charlie Johnson assisted in many ways. Bill Fairweather in particular helped me a great deal to understand the concepts and the data I was dealing with. The staff of the MSU-NIMH Innovation Diffusion Project helped in many ways as well. Esther Fergus and Joe Avellar provided much emotional and intellectual support throughout the project. Dennis LaFave kept me laughing and

in good spirits. JoAnn Ohm sent out a lot of questionnaires and saved me a lot of work.

The National Institute of Mental Health supplied financial support for this research, as part of a grant to Lou Tornatzky and Bill Fairweather. Lou and Bill's decision to provide me with part of this funding is greatly appreciated.

Last, but not least I want to thank my wife, Carol, and my son, Ethan, for putting up with what they did while this research was in progress. The project involved much travel and time spent away from home, particularly during Ethan's first year in the world. I hope you think it was worth it.

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CHAPTER I

INTRODUCTION

It is a truism that our present-day society is beset by more and more problems. Paradoxically at the same time, more and more solutions are being developed by scientists and others, but relatively little has been done in a systematic way to promote the use of these solutions among the persons who could most benefit by them. Havelock (1973) has written about a new "science" of knowledge utilization that might provide systematic techniques for the diffusion of innovations. Havelock and Rogers and Shoemaker (1971) have reviewed recent developments in this area.

The path of an innovation or new program from its initial conception to mass adoption is long and arduous. People seem to inherently resist change, whether that change might benefit them or not. As LaPiere (1965) has pointed out, almost all innovations, from the wheel to the computer, have been feared, ridiculed, and resisted. Given the relative success of the human race, it may be said that, in the past, society has managed to adopt those innovations it needed, while discarding those it deemed useless. This argument states that change takes place slowly because the "natural processes" in society need time to determine an innovation's suitability. Although that point is moot, it is clear that while the need for change is accelerating as society grows more complex, the

capacity of individuals and organizations to cope with change is becoming increasingly strained (Fairweather & Tornatzky, 1977; Toffler, 1971). Thus, it seems necessary to make the change process more rational and efficient.

As evidenced by Havelock's (1973) and Rogers and Shoemaker's (1971) reviews, and some more recent work (Emrick, 1977) innovation diffusion research has been steadily increasing in recent years. However, surprisingly little of that work has involved experimentation to test the effects that various interventions can have on the diffusion process. Fairweather, Sanders, and Tornatzky (1974) have provided an example of what can be done toward this end by performing an experiment to diffuse an exemplary mental health innovation, the Community Lodge. The present study is an extension of that work, and attempted to diffuse the same innovation.

Frequently (and particularly in the area of human services) an innovation must not only be accepted by an individual, but must be introduced into an organization. Although organizations are indeed composed of individuals, the whole in this case is very different from the sum of its parts. While organizations often resist change for many of the same reasons as do individuals, due to the complexity of most organizational structures additional problems present themselves when an organization is the target of a change effort. As a consequence, in order to adequately discuss ways of overcoming resistance to change, it will be necessary to divide the discussion into two parts: 1) problems of individual resistance; and 2) problems of organizational resistance.

Problems of Individual Resistance

Among the primary causes of resistance to change is simple fear of the unknown. As LaPiere (1965) has pointed out:

> Men always and everywhere accept with considerable complaisence what is familiar to them, whatever it may be and however disagreeable it may seem to members of another, different society, apparently because almost anything familiar is less disturbing emotionally than is something unknown. It is an oversimplification to say that men fear the unknown; it would be better, perhaps, to say that what is designated as fear (or apprehension, dread, or the like) are those emotional disturbances that are induced by the contemplation of or exposure to what is unknown or unfamiliar and hence unpredictable (p. 177).

Havelock (1973) says that this fear, or threat, occurs if the new behavior required by an innovation represents unfamiliar elements, or if the change threatens an individual's status. LaPiere agrees, calling the latter a "rational basis for resistance" in that an innovation may be contrary to an individual's self-interest. Fear, and consequently resistance, occurs because the individual is uncertain as to the outcome of his adopting the innovation. If the change agent can clarify the ambiguity surrounding the innovation the potential adopter will be more certain about the outcomes of adopting it.

Uncertainty. Rogers and Shoemaker (1971) have described the change process in a different fashion. They ascribe five characteristics to an innovation. These are (1) observability; (2) trialability; (3) relative advantage; (4) compatibility; and (5) complexity. Four of these five characteristics (observability, trialability, complexity and compatibility) are directly related to

uncertainty about the innovation. If the potential adopter can observe the effects of the innovation, he will be more certain about the results if he adopts it. Similarly, if he can try the innovation (or a part of it) before committing himself to it, he will be less likely to fear it. Finally, if the innovation is compatible with his present technology or belief system, he will have less reason to be uncertain.

Schon (1967) has also discussed resistance to change in terms of uncertainty. In a manner similar to that of March and Simon (1958), Schon discusses the differences between risk and uncertainty. Risk is the likelihood that an action will produce an unwanted result. Note that in risk there is a known probability involved. In uncertainty, the probabilities involved are unknown. Uncertainty can be the result of two things, either not enough information or too much information. While it is probably obvious how insufficient information could result in uncertainty, the problem of too much information may be less clear. The difficulty with a surfiet of information is in the individual's or organization's inability to process it. An overwhelming amount of information simply overcomes one's ability to organize and make sense of what one has. Schon feels, as does Galbraith (1967) that this inability to process the information available is one of the major causes of uncertainty leading to resistance to change.

Reduction of Uncertainty: Communicator Credibility. It would seem then that the best way to reduce the uncertainty involved

in resistance to change is to provide better means of understanding and processing the information that is available. This leads to two courses of action. One option would be to alter the organizational systems involved so that information can be processed more effectively and uncertainty thereby reduced. This clearly has greater implications for organizational resistance and will be discussed at length in that section. A second alternative would be to alter the quality of the information itself so that it is more comprehensible and believeable. This later course would have direct impact on individuals.

There are a number of ways to improve the quality of information that is being provided. Clearly, if someone is more certain that the information he is receiving is accurate, his uncertainty about the effects of an innovation will be reduced. The quality of the information, as perceived by the potential adopter, is mediated by certain characteristics of the communicator. For the most part these relate to how credible the change agent is perceived as being. Some of the factors involved in credibility are the legitimacy of the change agent's role (Havelock, 1973), the trustworthiness, prestige, and perceived expertise of the change agent (Hovland & Weiss, 1951; Hovland, Janis, & Kelley, 1953), and whether the potential adopter believes the change agent has an ulterior motive for his activities (Walster, Aronson, & Abrahams, 1966). Another crucial factor in communicator credibility is how similar the communicator and recipient are. Brock (1965) showed that "the extent that the recipient perceives that he and the communicator share an

attribute, that is have a similar relationship to an object, to that extent is the recipient's behavior with respect to that object likely to be modified by the communicator's influence attempt" (p. 650). Berscheid (1966) also showed that amount of opinion change is related to communicator-recipient similarity, as long as that similarity was relevant to the opinion being changed.

In a more recent study Tuppen (1974), using cluster analysis, found that there were five dimensions having to do with communicator credibility. These were trustworthiness, expertise, dynamism, charisma, and co-orientation. This last related to how similar the recipient of the communication thinks the communicator's ideas are to his own.

Rogers and Shoemaker discuss characteristics of the change agent that make adoption of an innovation more likely. One of the primary characteristics is homophyly (or similarity) between the change agent and the potential adopter. Roger's rationale for this principle is that communication is facilitated when two individuals are similar.

One of the reasons behind the rather consistent finding that similarity makes a communicator more credible could have to do with the reduction in uncertainty accompanied by what Festinger (1954) called the Social Comparison Process. Under conditions of anxiety people tend to evaluate themselves (and their abilities, opinions, and emotions) by comparison with others. Schacter (1951) referred to this process in another way by saying "on any issue for which

there is no empirical referent, the reality of one's own opinion is established by the fact that other people hold similar opinions" (p. 191). He later qualified this (Schacter, 1959) by saying that comparison could only be effectively made if the others were similar in some relevant manner. Radloff (1961) stated the main hypothesis to be derived from Social Comparison Theory: "A person who is uncertain about the correctness of one of his opinions, for which he finds no objective criteria available by which to evaluate its correctness, should seek affiliation with other people in order to evaluate his opinion via social comparison." Radloff provided subjects with information about the opinions of a) no others, b) irrelevant others, c) peers, d) experts. The subjects need for social comparison decreased from a) to d). This showed that tendencies toward comparison varied according to strength of evaluative need.

These studies add weight to the above discussion concerning information. The potential adopter of an innovation is likely to perceive information as being of higher quality (with the consequent reduction in uncertainty) if he perceives the change agent as being more credible and similar. Social comparison theory seems to provide an underlying explanation for this process.

Problems of Organizational Resistance

It might appear that organizational resistance to change would have no relationship to individual resistance, however organizations resist change for many of the same reasons as individuals.

One of the most important of these is the degree of uncertainty associated with the innovation. However, the process involved in reducing this uncertainty by individuals in the aggregate may be very different from that used by a single individual. The reasons for this relate to the very nature and purpose of organizations.

Organizational structures. One of the primary functions of an organization is to reduce uncertainty about the task it is to perform (Schon, 1967; Zaltman, Duncan, & Holbek, 1973). A variety of organizational structures have been developed to enable organizations to deal with uncertainty. In a classic bureaucracy, such as that described by Weber (1947), a rule is available to answer every question, a routine available for every task. Thus, uncertainty is theoretically eliminated by the provision of rules and a chain of authority to respond to all situations. Unfortunately, except for the most routine tasks, it is impossible to derive a set of rules to cover every possible circumstance. In addition, those rules, once developed are highly resistant to change. As a consequence, "bureaucracy, like other forms of organization, discourages the emergence of changes from within and resists the impact of changes imposed from without" (LaPiere, 1965; p. 409). The potential introduction of an innovation threatens the entire structure of the organization, since (if the innovation is of any consequence) a large number of rule changes and unorthodox decisions will have to be made. However, some types of organizations are better equipped to deal with change than others.

A number of organizational theorists have developed what are known as "contingency theories" of organizational structure. Two of these, Litwak (1961, 1968) and Perrow (1970) contend that organizational structure should depend on the nature of the task being performed by the organization. In Litwak's model, an organization that needs to perform a highly routinized, uniform task should utilize a formal, bureaucratic structure. On the other hand, primary groups are better suited to perform tasks which are non-uniform or where expert technical knowledge is not required. An example of such an instance would be when there is no knowledge about the task (so that experts cannot be trained) or when the task is so complex and non-routine that rules about it cannot be made. Such a task requires a relatively informal "human relations" type of organization. An organization that must perform both types of tasks must include components that are either bureaucratic or informal, with each having its own area of concern. Linkage roles are necessary to keep the two components on the same track. Certainly a considerable amount of resistance would be expected when an organization that was set up to perform one type of task is called to perform another. A bureaucratic organization called upon to perform a non-uniform task might be simply unable to perform for lack of guidelines. A human relations type of organization that was required to take on a series of routine tasks would be operating at a very inefficient level. In either case resistance would be expected due to the uncertainty arising from an unusual situation. Transformation of the organization into another format might

actually be necessary for the organization to be able to accomplish the task at all. A typical example would be the formation of what Litwak calls a "professional" organization. This is a type involving division into components with links between them. Hall (1962) has provided some evidence to support Litwak's model. Thus, there would seem to be two "basic" organizational structures, which for the sake of convenience will be called bureaucratic and human relations. One, the bureaucratic, is designed for stability, while the other, human relations, is designed for change. A considerable body of research has provided evidence for this assertion (e.g. Burns & Stalker, 1961; Hall, 1962; Lawrence & Lorsch, 1967; Hage & Aiken, 1970; Baldridge & Burnham, 1975). In the middle is Litwak's "professional" organization, containing some elements that are bureaucratic, some that are human relations.

The existence of these differing structures can have great impact on the innovation process. Zaltman and Duncan (1977) consider the innovation process to include two phases, initiation and implementation, each of which requires different structures. The initiation stage requires flexibility and decentralization, in order to encourage a flexibility of thought and action that is needed to initiate change. The implementation stage requires a more formal, structured, task oriented structure to enable the organization to accomplish the specific steps necessary to actually set up a new program or implement some technological innovation. Thus not only is it possible for an organization to have differing structures

in different units, but that may actually be necessary for complete adoption of an innovation to take place.

Linkage and Boundary Spanning

One point that has not been discussed is the connection between the two types of organizations. Communication between initiating and implementing units is obviously essential, however the structural differences are often a source of friction which interferes with communication. In addition, some connections need to be made with outsiders in order to gain necessary input in the form of new ideas, suggestions for change, and objective feedback.

Havelock (1973) has provided a detailed discussion of this concept, which he calls linkage. In his discussion Havelock describes ten characteristics of organizations that inhibit knowledge flow and change. The focus here will be on three of these. The first is the presence of a "coding scheme barrier." By this he means that members of an organization, because of their common experiences and interests, develop a unique vocabulary and means of communicating. This enhances stability, but also prevents effective communication with outsiders.

The second characteristic is related to the coding scheme barrier, that is the stable social structure and social relationships within the organization. Because any change is likely to disrupt the stability of these relationships it is likely to be resisted. The third characteristic is related to the first two and that is fear of the "malevolence of outsiders." "The boundaries which separate the

organization from its environment (e.g., buildings, dress, rules) encourage the formation of organizational myths which help members to deal with the uncertainty and ambiguity of change brought on by outside forces. Thus knowledge from the outside can be seen as a threat to the organization, not only in terms of upsetting the orderliness as a consequence of deliberate change, but also as a direct maligning of the organization and its members" (Havelock, 1973, p. 6-8). One of the most important ways of overcoming these organization barriers is through the use of linking roles between the developer of an innovation and the potential adopting agency.

One type of linkage role is that of change agent. Frequently the actual innovator is neither willing nor able to advocate change himself (LaPiere, 1965). Therefore an advocate takes the role of creating the linkage between the innovation and the potential adopter. Havelock divides this particular role into three subtypes (conveyor, consultant, and trainer); however, the common element in all of them is that they are outside the organization. Consequently, they are liable to encounter all of the problems involved in attempting to bridge the organization barriers to change. Another role is necessary, what Havelock calls the Innovator role. This is not necessarily the inventor of the new process or product. This person may only be an innovator in the context of his social system, in that he is the first person in that system to adopt or advocate the innovation. While this type of innovator may not be an actual opinion leader he may act as "a demonstrator and quasi-opinion leader for the <u>real opinion leader</u>" (p. 7-14). Thus, this type of

linkage role may be said to to provide the first true link into the organization. A link of this sort may provide the possibility for social comparison processes to take place within the organization primarily because the "innovating" individual is likely to be much more similar to people within the organization than is an outside change agent. Thus, individual uncertainty may be reduced in a manner favoring the innovation.

Thompson (1967) has discussed the linkage concept in another fashion. Thompson stresses the need for organizations to have "boundary-spanning structures." These are units within the organization that have the responsibility of linking the organization with its environment, and dealing with the differing demands and structures that exist there. Thompson emphasizes the need for such boundary-spanning units to be structured differently from the rest of the organization, and the problems these units may have as a result. He also claims that organizations that face a greater need to change will have greater numbers of such units.

From the point of view of an outside change agent then, one key to overcoming organizational resistance to change is the creation of one or more linkage roles, both within the organization and with its environment. In addition, it may be necessary to encourage the formation of a variety of organizational structures, depending on the existing structure and the type of innovation being introduced. In the case of a mental hospital adopting the Community Lodge, it could be necessary to encourage the formation of a small, informal group that would initiate the new program. It might also

be necessary to create linkage between the potential users of the innovation (at the target hospital) and the originators. Linkage would also be needed between the small innovative group and the unit that might be implementing the program, and with the hospital at large.

Site Visits as a Technique for Overcoming Resistance to Change

From the preceding discussion it can be seen that the following are some of the key problems in disseminating innovations to organizations: 1) Reducing individual uncertainty; 2) altering organizational relationships; and 3) creating boundary spanning mechanisms. While a variety of techniques have been used to overcome these problems (Rogers & Shoemaker, 1971; Havelock, 1973; Emrick, 1977) some have received less attention than others. One technique that has been the object of relatively little research is the use of a visit to the site of an innovation. Theoretically, a site visit should resolve a number of difficulties described above that may arise due to uncertainty. At the actual site of an innovation the visitor is provided with information of much higher quality than he could receive through other means such as brochures or workshops. The visitor is shown as much information as he is capable of interpreting with his own eyes and ears. He is in a position to direct questions about the innovation to the people most qualified to answer them, the people who use the innovation. Thus, uncertainty about the innovation will be reduced because the potential adopters have become more familiar with it. In the same

way, the observability of the innovation, as described by Rogers and Shoemaker (1971) will be improved.

Assuming the visit is sponsored by an outside agency the operators of the innovation would be the most credible people to talk to about it. Certainly they know more about how it operates than anyone, and since they are not going out of their way to make a persuasive communication they should be perceived as having little to gain from having others adopt. As many researchers have shown (Hovaland & Weiss, 1951; Hovland, Janis, & Kelly, 1953; Walster, Aronson, & Abrahams, 1966; among others), these characteristics of the communicator improve his credibility, resulting in increased opinion change.

A site visit provides potential adopters with peers with whom they can compare themselves (by way of Festinger's Social Comparison Process) in order to reduce uncertainty. This would especially be the case if the visit took place shortly after the visitor had received information about the innovation, thereby making the comparison more salient. In general these peers would be much more similar to the potential adopter than would the typical outside change agent, who is often a professional consultant. With a peer acting as a change agent the probability of acceptance should increase, as Brock (1965), Berscheid (1966) and Tuppen (1974) have shown.

A site visit can also help in an organizational sense. Assuming that the individual site visitor has been convinced that his organization should adopt the innovation he would then become an

internal advocate. In a sense he would be playing the Innovator role as described by Havelock (1973).

While the concept of site visits seems to be widely accepted (Havelock, 1973; Rogers & Shoemaker, 1971), there have been relatively few experimental tests of their effectiveness. It has been widely used by the agricultural extension specialist and county agents with their demonstration farms. When one farmer in an area has been convinced to try a new product or procedure (such as hybrid corn, or a new plowing technique) other farmers are then given the opportunity to visit the demonstration farm or talk with that farmer socially. Clark (1962) related this technique to the field of educational innovation.

> Education today may have roughly the same relationship to its practitioners that existed in the field of agriculture in the latter part of the 19th century. At that time, the primary vehicle of communicationto the practitioner was the printed word from research to practitioner. The impact on agricultural practice was slight. Interposed now between the researcher and practitioner are two levels of translation. The extension specialist can read the research and translate it into something the county agent can understand. The county agent, however, does not typically pass this information directly on to the practitioner. Instead he provides an opportunity for the farmer to visit another farm in his neighborhood where the new practice is being employed. The situation is a real one. The farmer using the new method is risking his own money on his own farm. The visiting farmer has a chance to see what is going on and talk to the experimental farmer about it (p. 111).

Certainly a similar situation exists today as regards researcher-practitioner communication in many fields, such as mental health, public health, or social services. It would seem likely that such fields could benefit greatly from the concept used in agriculture.

Richland (1965), in an attempt to test the effectiveness of the agricultural field extension service concept as applied to education, tested what he called "Traveling Seminars." These were groups of thirty "educators" who traveled around visiting school sites that had exemplary innovations. At the conclusion of the site visits the four seminar groups gathered in one location to discuss what they had seen and what they were going to do. Unfortunately, the seminar groups included no teachers, although school administrators were included, in addition to representatives of state departments of education and colleges of education. During their five day tours each group visited from three to five school districts and observed from seven to eleven different innovations. The school districts from which the administrators were chosen were selected because of "a known interest in research," among other criteria. In a follow-up one year later the school administrators were asked questions about how many innovations they had adopted or were considering adopting. This was compiled into an "innovation index." There was a significant difference between the tour groups and a no treatment control group both on innovation gain scores and on an Analysis of Covariance of the post-test scores. Unfortunately, there may have been some bias in the control group due to the inclusion of some non-volunteers from the experimental groups. While showing that a site visit plus a conference could help to make schools more innovative, Richland did not attempt to influence educators to adopt a specific innovation. In addition, no attempt was made to isolate the effect of the site visits nor was an attempt

made to compare the effectiveness of site visits with that of other persuasion techniques.

Glaser and Coffey (1967) attempted to diffuse a more specific group of innovations and did test a number of specific techniques. Their "innovation" was an organization for the mentally retarded that was using a number of specific (although unrelated) practices. Their measure of adoption was the number of these practices that their target organizations adopted. They used three persuasion techniques: (1) an attractive booklet that described the various practices used by the innovating organization; (2) the same booklet, plus a combination visit and conference at the site of the organization; and (3) the booklet, site visit-conference, plus a consultation visit from the founder of the exemplary organization. When asked if they had adopted one or more practices, the organizations in the booklet alone condition were significantly less adoptive ($p < .10$) than the organizations in the other two conditions. However, using an overall change score there was no difference between experimental conditions, although all three groups showed significantly more change than did a no treatment control group.

Glaser and Ross (1971) attempted a much more specific and controlled experiment. Their innovation this time was a specific type of therapy to be used in a variety of mental health organizations (e.g., Mental hospitals, Community Mental Health Centers, etc.) called Saturation Group Therapy (SGT). This study used the same conditions as Glaser and Coffey did. This time however there

was no effect at all. Not one organization adopted the innovation after a six-month follow-up, although at least two seemed as if they probably would. Glaser and Ross believe the problem lies in the nature of their innovation. While it was ideal from their research standpoint, it did not have sufficient relative advantage, nor was it sufficiently compatible with the potential user systems.

In a more recent study Larsen, Artunian, and Finley (1974) used site visits in an attempt to make Community Mental Health Centers (CMHCs) more innovative, in general. They had three experimental conditions, plus a control group. These conditions were: (1) Written materials were sent to the CMHC that described a number of innovations and where more information about them could be obtained; (2) Written materials were sent, plus the CMHC was provided with a set amount of money which they could use to send staff to visit the site of any innovation described in the materials; and (3) In addition to the written materials and the money for the site visits a consultant visited the CMHC prior to the site visits to discuss innovation and any of the specific innovations in the materials. The results of this experiment showed no significant differences between conditions as to innovativeness. In general the CMHC staffs liked all of the treatments and thought they were very useful.

With the exception of the Richland study it would seem that most of the experimental work to date has not shown site visits to be a very effective technique for the diffusion of innovations. However, each of the studies has had some methodological flaw which

hampered its effectiveness. Probably the major weakness of all of the studies was the lack of direct assistance to help the potential adopters to implement the innovation. Fairweather, Sanders, and Tornatzky (1974) have shown that this is crucial to get a significant rate of adoption. What may have happened, (and certainly did happen to Glaser and Ross) is that so few adoptions took place that there was no chance for the site visit to take effect. In addition none of the studies actually tested for the effectiveness of the site visits alone, it was usually part of a conference. Often no attempt was made to involve the whole organization. In other words, information was passed to only one or two individuals in an organization, one of whom made the site visit. Such a situation is likely to lead to an authoritarian type of decision. Rogers and Shoemaker (1971) and Fairweather et al. (1974) have shown that such decisions are less likely to lead to change. Thus it would seem that site visits, a concept with much theoretical backing but little direct evidence in its favor, is still in need of empirical testing as to its effectiveness.

The Present Study

This study experimentally tested the effects of a site visit on adoption of a specific innovation (the Community Lodge) by a national sample of mental hospitals. A number of mental hospitals were provided with a workshop about the Lodge program, after which half of the sample was offered the opportunity to send a staff

member to visit the site of a hospital which was operating a number of Lodges.

Hypotheses

A number of hypotheses were made concerning the effects that such a visit ought to have on a mental hospital and its staff. These were divided into three categories.

Effects on social process. The first can be called direct effects of the visit on social process variables. If the site visit is to have any effect at all, the site visitor must talk to others about the visit and act as an advocate for the program. This results in two hypotheses:

1. A site visit will increase the amount of discussion about the Lodge among hospital staff.
2. A site visit will result in increased advocacy for the program at the target hospital.

Effects on intervening variables. It was suggested that uncertainty about the innovation might be an intervening variable between discussion about the program and actual adoption of it. Uncertainty can have many components, three of which appear to be of importance in this instance:

3. A site visit will reduce the amount of uncertainty hospital staff feel concerning their knowledge about how-to set up a Lodge.
4. A site visit will reduce the amount of uncertainty staff feel concerning the effectiveness of the Lodge program.
5. A site visit will reduce the amount of uncertainty staff feel concerning the feasibility of the program.
6. A site visit will reduce overall uncertainty about the program.

Boundary spanning was noted above as an important variable in the innovation process that might be affected by a site visit.

7. The extent of external Boundary Spanning will be increased as a result of the site visit.

Other variables that might be of importance as interveners in the adoption process are attitude toward the program, and knowledge about the program. This resulted in two more hypotheses:

8. A site visit should result in an improved attitude toward the Lodge program.
9. A site visit will result in hospital staff having more knowledge about the program.

Effect on adoption of the lodge. Finally, as a result of these intervening processes:

10. A site visit should result in increased movement toward adoption of the Lodge program.

CHAPTER II

METHOD

The Innovation to be Disseminated

The innovation that was to be disseminated in this experiment was the Community Lodge Program, which was developed by George Fairweather in the 1960's as an effective method of treatment for chronic mental patients. The Lodge program consists of two parts, a hospital phase, known as the Small Group Ward (Fairweather, 1964), and a community phase, known as the Lodge (Fairweather, Sanders, Maynard, & Cressler, 1969). A central idea of the program is the development of intense group cohesion and peer dependence through the use of a variety of group reinforcement techniques. A key element in maintaining a strong group identity is a reduction in staff influence over individual members of the group. This is in direct conflict with the traditional role of the mental health professional as a "helping" person. The program also has a strong community orientation, which runs counter to the very insular role that most mental hospitals have assumed. The Lodge in particular is very complex and difficult to implement, involving a variety of tasks that are not typically included in the training of most psychiatric hospital personnel.

Sample

Hospitals. The sample was twenty-four (N = 24) state hospitals (Appendix A) that (1) had not been contacted about the Lodge innovation in the seven years previous; (2) were within 1000 miles of E. Lansing, MI; (3) agreed to have a free workshop on the Lodge program; and (4) agreed to permit one staff member to make an all expense paid site visit, should that opportunity be provided. These hospitals had all been contacted by Fairweather, Sanders, and Tornatzky (1974) in their diffusion study, and had been assigned a change score by them, depending on what steps they had taken toward adoption of the Lodge. Hospitals were matched on that change score and then randomly assigned to either experimental or control conditions.

A total of 44 hospitals were contacted in order to obtain the 24 that met all of the above criteria. Twenty hospitals that were contacted were either unwilling or unable to have the workshop. All hospitals that agreed to have the workshop also agreed to permit staff to make the site visit.

Individual respondents. A total of 606 individuals attended the 24 workshops and filled out a Workshop Questionnaire. More than 90% of these respondents were employees of the hopsital where the workshop was given. The rest were representatives of various community agencies. Of those respondents, 386 responded to a follow-up questionnaire that was mailed to them.

Research Design

The design of the experiment was a simple, two cell design (Figure 1). Hospitals were matched on their change score from the Fairweather, Sanders and Tornatzky (1974) study and then were assigned to either experimental or control conditions. Thus, there were twelve hospitals in each condition.

Procedure

The study consisted of four phases (Figure 2), as follows:

Approach Phase. Two brochures describing the Hospital-Community Treatment Program (the named used in the project to represent the combination of Small Group Ward and Lodge programs) was sent to all hospital superintendents along with a cover letter (Appendix B) describing the kinds of assistance that could be provided to the hospital in setting the program up. After approximately ten days the superintendent was called. A brief description of the Lodge and the assistance that could be provided was presented (Appendix C), and the superintendent was asked if he would allow a workshop to be presented on the Lodge at his hospital. A decision was not demanded at this point, although the superintendent was encouraged to make one. One week after the telephone call a reminder letter (Appendix D) was sent. Ten days after that a follow-up call (Appendix E) was made to obtain a decision, if one had not been reached. Workshop volunteers then moved on to the Persuasion Phase.

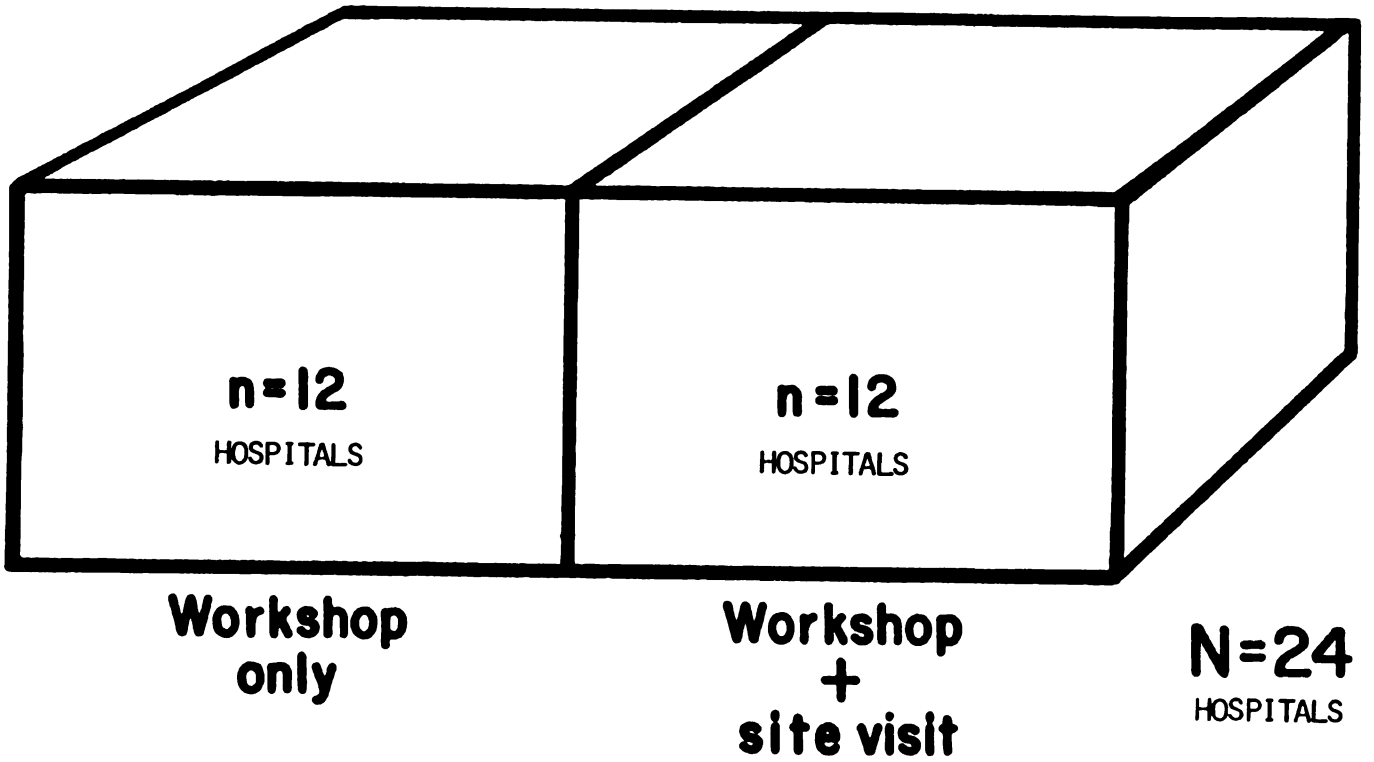

Figure 1

Design of the Site Visit Experiment

Phase	Time Period	Activities	Data Collected
Approach (44 hospitals)	0-55 days after initial contact	Make arrangements for workshop	
Persuasion (24 hospitals)	42-146 days after initial contact	Workshop at hospital	Workshop Questionnaire
Site Visit (12 experimental hospitals only)	13-98 days after workshop	1 staff member makes Site Visit	Site Visitor Questionnaire
Follow-up (24 hospitals)	3-13 months after workshop	Send Mail Questionnaire Consultation (when needed)	Mail-Out Questionnaire Telephone Follow-Up Questionnaire

Figure 2

Flow Chart of Activities and Data Collection

Persuasion phase. The persuasion phase consisted of two parts, a brochure mailing and a workshop presentation.

Brochures were mailed along with a letter confirming the workshop date (Appendix F) to the hospital superintendent or other designated contact person. These were to be distributed to all personnel that were expected to attend the workshop. Distribution of these brochures is uncertain, although 42% of the staff who attended the workshops said that they had read the brochure.

A one day workshop at the hospital constituted the bulk of the persuasion phase activity. This included a two hour lecture, complete with slides and a movie, a question period, and a three hour discussion of the steps necessary to set up a Small Group Ward. A schedule for the workshops can be found in Appendix G.

At the conclusion of the lecture and question period the workshop participants were informed about the kinds of assistance that could be provided to them, should they request it. This assistance included: (1) eight copies of a manual describing in detail the steps necessary to set up a Small Group Ward (Tornatzky, Fleischer, Avellar, Fergus, & Fairweather, 1976); (2) two copies of a manual describing in detail the steps necessary to set up a Lodge program (Avellar, Dittmar, Fergus, Tornatzky, Fleischer, & Fairweather, 1976); (3) free telephone consultation concerning the program; (4) the possibility of a free two day consultation visit to the hospital, if a Small Group Ward had been set up and operated for at least 60 days; and (5) for those hospitals in the Site Visit (experimental) condition only, the opportunity for one member of the

staff to make an all expense paid visit to a state hospital in Minnesota that had a functioning Small Group Ward and several lodges.

In the afternoon, at the conclusion of the workshop, participants filled out the Workshop Questionnaire (Appendix H). Participants who left early were asked to fill this questionnaire out before they left. In the Site Visit condition, after the questionnaires were completed the participants were asked to decide who would be the one to make the Site Visit. In about half of the hospitals a decision was made immediately. In the rest of the hospitals the decision was made within two weeks.

Site visit phase (experimental group only). Each hospital in the Site Visit condition was invited to send one staff member on an expense paid visit to an exemplary Lodge program. All twelve hospitals in the Site Visit condition participated in this phase of the experiment. Two of those hospitals chose to send an additional staff member on the visit, at hospital expense. It should be noted that there were no activities in this phase for hospitals in the Control condition.

Those individuals who were selected as site visitors were informed by mail and telephone about the details of their trip to Minnesota (Appendix I). The visitors were asked to make their own arrangements for transportation (they were later reimbursed) and to make their own way to a designated hotel, where they were met by a member of the hospital staff in the morning.

It should be noted that from three to six individuals were involved on each of three site visit dates. On the first date three people from different hospitals were involved. On the second date, about a month later, five people from four hospitals participated, and on the third date, another month later, there were six individuals from five hospitals.

The hospital that hosted the Site Visits has one of the best examples of a Community Lodge program in the nation. Their initial Lodge was set up eight years ago, as a result of the Fairweather, Sanders, and Tornatzky (1974) diffusion study. The staff had remained in contact with the Michigan State research group on a regular basis. Since their initial Lodge they had set up five additional ones (as of this writing). They were a very enthusiastic group, and when presented with the idea of hosting the site visits, were quick to accept. It was agreed to pay $350 for each of the three visits, as compensation for staff time and expenses during the visits. This money was donated to the Lodges.

A sample schedule for the Site Visits can be found in Appendix J. During their two day stay the visitors had the opportunity to meet with staff and residents of the Small Group Ward and Lodge programs, to observe the various meetings that are a part of the program taking place, to visit Lodge residences, and to visit with Lodge members while they were working in their place of business. Ample opportunity was provided for the visitors to talk with the residents and staff on an informal basis. Before the

visitors left for home they each filled out a Site Visitor Questionnaire (Appendix K).

Follow-up and consultation phase. Three months after the workshop all workshop participants (in both conditions) were sent a Mail-Out Questionnaire (Appendix L). Those individuals who did not return the questionnaire were sent a Follow-Up letter with an additional questionnaire (Appendix M). All questionnaires were sent with a business reply (postage-paid) envelope for the respondents' convenience. Of the 606 workshop participants who were sent the Mail-Out Questionnaire, 386 returned them, for a response rate of 63.7%.

Follow-Up telephone calls were made to the designated contact at the hospital at the following intervals.

1. 3 months after the workshop
2. 6 months after the workshop
3. 9 months after the workshop
4. 13 months after the workshop

The calls had two objectives. The primary objective was to collect data concerning the extent to which the hospital was making progress toward setting up the Small Group Ward or Lodge (Appendix N). The secondary purpose was to provide telephone consultation assistance or to answer questions concerning the program.

There was also additional assistance available. Staff at the workshop were informed that they could receive direct consultation assistance in setting up the Small Group Ward or Lodge if they had operated a Small Group Ward for at least 60 days. This consultation assistance consisted of a two day visit by a consultant.

The first day involved a trouble-shooting procedure to find and solve problems with the Small Group Ward. The second day consisted of discussion about how to take the first steps toward setting up a Lodge. Additional copies of the Lodge manual were also provided at this time.

One hospital began a Small Group Ward three months after the workshop, but did not request consultation. Three hospitals began Small Group Wards in the interval between six and nine months and received consultation in the interval between nine and thirteen months. Thus, there were no consultation visits made until after the nine month follow-up period had passed.

Measurement

Measurement for this study involved the use of four questionnaires, which were composed of a number of different scales and individual items (see Figure 3). The four questionnaires were: the Workshop Questionnaire (Appendix H), the Site Visitor Questionnaire (Appendix K), the Mail-Out Questionnaire (Appendix N). Composition of these questionnaires is summarized in Figure 3.

A number of questionnaire items and scales were developed for the purpose of testing the specific hypotheses discussed in the previous chapter. The various scales are discussed in detail below, with a summary of which measure tests which hypothesis provided in Figure 4.

Communication network item (Appendix O). This was an item on the Mail-Out Questionnaire that was designed to determine the

Workshop Questionnaire	Mail-Out Questionnaire	Site Visitor Q	Phone Q
a. Certainty Scale How-to Knowledge subscale Effectiveness subscale Feasibility subscale	a. Certainty Scale How-to Knowledge subscale Effectiveness subscale Feasibility subscale	a. Similarity Scale b. Usefulness of visit questions	a. Change Scale questions b. Questions about visits to other hospitals
b. Attitude Scale	b. Attitude Scale		
c. I-E Scale	c. I-E Scale		
d. Knowledge Test	d. Knowledge Test		
e. Participation questions	e. Participation questions		
f. Age, work history, education	f. Communication Network question		

Figure 2

Contents of Questionnaire

Hypothesis	How Measured
1. Site Visit (SV) should increase discussion about program.	1. a. Q1 & Q2 on MOQ b. Communication Network question on MOQ
2. SV will increase advocacy	2. Q5 on MOQ Network Question on MOQ
3. SV will reduce How-To Uncertainty.	3. How-To Certainty subscale on MOQ
4. SV will reduce Uncertainty about eEffectiveness.	4. Effectiveness Certainty subscale on MOQ
5. SV will reduce Uncertainty about Feasibility	5. Feasibility Certainty subscale on MOQ
6. SV will reduce Overall Uncertainty	6. Overall Certainty Scale on MOQ
7. SV will increase Boundary Spanning.	7. a. Visits Question on Phone Follow-Up Q. b. #Letters sent to Consultant c. #Calls made to Consultant
8. SV will improve Attitude toward program.	8. Attitude Scale on MOQ
9. SV will increase knowledge about program.	9. Knowledge Test on MOQ
10. SV will increase movement toward adoption of program.	10. Change Scale derived from Telephone Follow-Up Calls

Figure 4

Measurement of Hypotheses

extent to which each respondent had communication concerning the Lodge with each other respondent. Data from this item was used to determine whether the Site Visit intervention increased discussion and advocacy about the program.

Certainty scale (Appendix P). This scale was designed to measure overall uncertainty about the program. It was composed of three subscales: (1) Certainty of How-To Knowledge Subscale (Appendix Q). This subscale was composed of 10 items that had to do with the respondents' certainty of the extent to which they knew how to implement both the Small Group Ward and Lodge. Internal consistency reliability, or alpha (Guilford, 1954), for this subscale was .82; (2) Certainty of Effectiveness Subscale (Appendix R). This subscale was composed of five items having to do with the respondents' certainty that the Samll Group Ward and Lodge were effective programs. Internal consistency reliability for this subscale was .77; (3) Certainty of Feasibility Subscale (Appendix S). This consisted of three items having to do with the respondents' certainty that setting these programs up was feasible within the context of their hospital and community. The realiability of this subscale was only .56.

The combination of the three subscale scores resulted in the score for the overall Certainty Scale, which had 18 items and a reliability of .82.

Attitude scale (Appendix T). The Attitude Scale was composed of eight items, dealing with the respondents' agreement with the program and its components and with their belief that the program ought to be adopted by their institution. The internal consistency reliability of this scale was .88.

Knowledge test (Appendix U). This consisted of four multiple choice items designed to determine if the respondent had basic knowledge about the program. A respondent's score for this test was the number of correct answers out of the four.

Change scale (Appendix V). This was a scale composed by Tornatzky, et al., (1978) to determine the extent to which a hospital has moved toward adoption of the Small Group Ward or Lodge. There are seven steps involved in Small Group Ward adoption and 26 steps in Lodge adoption. A hospital's change score was calculated in the following manner: each step toward adoption of the Small Group Ward was given one point. Each step toward adoption of the Lodge was given .337 point. Thus, the maximum score a hospital could receive was (7 x 1) + (26x.337) = 15.75. It was necessary to weight the Lodge steps much less due to the number of steps involved as compared to the Small Group Ward. The assignment of seven points to Small Group Ward implementation and 8.75 points to Lodge implementation was based on previous archival data from several hospitals on the relative amount of time and effort involved in implementing the two respective subcomponents of the total program.

A hospital received a change score at each of the Follow-Up periods at 3, 6, 9, and 13 months after the workshop. The number of steps achieved toward adoption was derived from the Telephone Follow-Up questionnaire.

A number of additional measures were used in this study that were not involved in specific hypothesis testing. Their primary purposes were as measures that seemed to be important indicators of the process taking place during adoption. These included:

Internal-external locus of control scale (Appendix W). This was a modification of the Rotter (1966) I-E Scale, developed by Tornatzky, et al., (1978), following previous work by Bond and Tornatzky (1972). The modifications were designed to make the scale directly applicable to staff employed in a mental institution. This scale had eight items and a reliability of .78.

Similarity scale (Appendix W). The Similarity Scale was composed of seven items relating to how similar the Site Visitor felt his own institution was to the one he was visiting. It was used only on the Site Visitor Questionnaire. Its reliability was .76, with a sample of only 14.

In addition to data derived from the four questionnaires, some information was gathered about the hospital itself from the City and County Data Book (U.S. Census, 1974) and from the Hospital Data Book, published by the American Hospital Association (1977).

CHAPTER III

RESULTS

Equivalence of Treatment Groups

One possible difficulty that could have arisen with the study that was just described is the problem of "experimenter effects" (Rosenthal, 1966). Experimenter effects as bias in an experiment may occur when the experimenter is not "blind" to the treatment conditions and has the opportunity to affect his subjects' outcomes. This could be a problem in the present study, since there was only one experimenter/consultant (namely the author), and he was aware of which hospitals were in each condition. Since the bulk of the consultant's time with each hospital's staff was during the workshop, it may be that he presented his material differentially or said something different for hospitals in different conditions.

The best way to test for the possibility of experimenter effects would be to take measures of the outcome variables after the completion of the workshop, but prior to the time that the Site Visit took place. The Workshop Questionnaire meets the qualifications for such a test. The absence of differences on the measures contained in that questionnaire would offer strong support for a lack of bias on the part of the consultant. Table 1 is a summary of the Analyses of Variance (ANOVA) comparing the two conditions on the various scales and items on the pre-test (Workshop)

Table 1

Summary of ANOVA of Pre-Test Differences
Between Conditions

Variable	F	(df)	p
1. Years staff worked at hospital	.530	(1,22)	ns
2. Level of staff education	.245	(1,22)	ns
3. Staff age	.521	(1,22)	ns
4. Number journals read	3.381	(1,22)	< .1
5. Satisfaction with present programs	.114	(1,22)	ns
6. Personally involved in decision making	.089	(1,22)	ns
7. Staff discussion about workshop	.257	(1,22)	ns
8. Certainty of "How-to" knowledge	.171	(1,22)	ns
9. Certainty of feasibility	.108	(1,22)	ns
10. Certainty of effectiveness	1.000	(1,556)	ns
11. Attitude	.804	(1,345)	ns
12. Locus of control	.075	(1,22)	ns
13. Overall certainty	.014	(1,22)	ns
14. Knowledge	.237	(1,582)	ns
15. Position of staff	2.168	(1,22)	ns
16. Area of staff training	.001	(1,22)	ns

questionnaire. The table shows that there were no significant (.05 level) differences between the two conditions on their responses to the pre-test.

Another potential problem with this study could have arisen as a result of a differential return rate of the post-test (Mail-Out) questionnaire. If this occured it might indicate that different kinds of people were responding in different conditions, possibly biasing the results. Of 386 questionnaires returned, 202 were from the Site Visit condition, while 184 were returned from the Control condition. This difference is not significant ($t = 1.00$, 22df).

In addition, several ANOVAs were computed to test for the effect that a number of personal variables had on dropping out. For these analyses, whether or not an individual dropped out of the sample was treated as a dichotomous variable. Thus, it was possible to test for the effect that demographic variables and the Site Visit condition had on it. More important, it becomes possible to see if there was an interaction between the demographic variables and the condition in their effect on dropping out. Table 1a is the ANOVA table showing the effect of both the respondents' status position in the hospital and condition on dropping out. It can be seen that while position does have a significant effect ($F = 5.96$, $df = 4,586$, $p < .001$), condition does not, nor is there an interaction between position and condition. This lack of an interaction can be interpreted to mean that the intervention did not differentially effect individuals in the status positions as far as dropping out of the sample was concerned.

Similar results were found for variables such as area of training, education, age, and work experience of the respondents. To summarize, respondents in the two conditions appear equivalent at the time of post-testing.

Table 1a

Effect of Position and Condition on Dropping Out

Source	df	MS	F	p
Position (P)	4	1.438	5.956	< .001
Condition (C)	1	.403	1.671	ns
P x C	4	.106	.440	ns
Subjects	586	.242		
Total	595			

Effects on Social Process

Effect on discussion. The first hypothesis (see page 21) stated that the Site Visit should result in greater discussion about the Lodge taking place within the hospital. This hypothesis was tested in two ways.

The first involved staff perceptions about the amount of discussion. This was measured by two questions on the Mail-Out Questionnaire (MOQ). One asked the respondent to indicate how much discussion about the program took place among hospital staff (Appendix

K, Question 1). Table 2 indicates that the Site Visit did not significantly affect response to this question ($f = .447$, $df = 1, 22$, ns). Table 2 and many of the following tables may appear somewhat unusual to some readers. In this experiment hospitals are nested within conditions (Winer, 1976), and thus, the variance due to hospitals must be considered separately. If the differences between hospitals (the nested factor) are <u>not</u> significant, then the error terms may be pooled. Thus, in a situation where the hospital factor is significant it is used as the error term in computing the F ratio for condition. When the hospital factor is not significant, a pooled error term is used. In this case, there was a significant difference between hospitals ($F = 3.22$, $df = 22, 344$, $p < .001$) although not between conditions. This means that hospitals vary considerably on this measure, based on some organizational variables. The implications of this will be discussed in the next chapter.

Table 2

Effect of Site Visit on Perceived Discussion

Source	Mean Discussion			
	Site Visit 2.73		Control 2.62	
	df	MS	F	p
Conditions	1	.992	.447	ns
*Hospitals	22	2.218	3.222	.001
Subjects	344	.688		
Total	367			

* = error term used to compute F ratio

The other question having to do with perceived discussion asked the respondent to indicate how much discussion concerning the program he or she was personnally involved in (Mail-Out Questionnaire, question 2). The results shown in Table 3 indicate that there were no differences between conditions ($F = .203$, $df = 1, 377$, ns) or hospitals.

The second way discussion was measured was more direct. This involved the Communication Network Question (Appendix N). The difference between the two conditions on the mean discussion based on this question was not significant (Table 4; $F = 2.30$, $df = 1, 22$). Thus, discussion was not increased as a result of the Site Visit.

Effect on advocacy. Perceived advocacy was measured by a question on the Mail-Out Questionnaire (Question 5) that asked whether the respondent thought that there was an advocate for the Lodge in the hospital, and if so who that was. The differences between the two conditions on this variable were not significant ($F = .152$, $df = 1, 300$).

Advocacy was more directly measured by means of the Communication Network Question. In this case the presence of a sociometric "star" was determined in each hospital. This was defined as the individual who had the greatest number of incoming links in the network, that is, the person whom the most respondents named as someone they spoke with concerning the Lodge. Each hospital's "star" then received a communication score which was the mean of all of his links with other respondents. As Table 5 shows,

Table 3

Effect of Site Visit on Personal Involvement

	Mean Discussion			
	Site Visit 2.71		Control 2.77	
Source	df	MS	F	p
Condition	1	.323	.203	ns
Hospitals	22	1.673	1.053	ns
Subjects	355	1.590		
*Pooled error	377			
Total	378			

* = error term used to compute F ratio

Table 4

Effect of Site Visit on Mean Discussion Strength

	Mean Discussion			
	Experimental 2.80		Control 2.67	
Source	df	MS	F	p
Condition	1	.103	2.303	ns
*Hospital	22	.045		
Total	23			

* = error term used to compute F ratio

Table 5

Effect of Site Visit on Star's Mean Discussion

	Mean Discussion			
	Experimental 3.56		Control 3.18	
Source	df	MS	F	p
Condition	1	.851	3.494	$p < .10$
*Hospital	22	.244		
Total	23			$eta^2 = .137$

* = error term used to compute F ratio

the Site Visit hospitals' stars had marginally greater communication than did the stars from the Control hospitals ($F = 3.49$, $df = 1, 22$, $p < .10$). A measure of association, eta-squared, indicates that a fairly substantial portion of the variance (13.7%) in this type of discussion can be explained by the Site Visit condition. It should be noted that in seven of the twelve Site Visit hospitals, the site visitor was the communication "star." In eleven of the twelve Site Visit hospitals the site visitor was the person named most often as the advocate on Question 5 of the MOQ.

To summarize the results, described so far, there is some evidence to indicate that the Site Visit did have some effect on communication in the hospital, at least in terms of concentration of communication around one "star." This can be interpreted as the existence of greater advocacy taking place.

Effects on Intervening Variables

Effect on uncertainty. This was measured by use of the Certainty Scale, which was composed of three subscales.

1. Certainty of "How-To" Knowledge subscale - this subscale consisted of items asking the respondent to indicate how certain he was about his knowledge of how to set up the program. Table 6 shows that the Site Visit had a significant effect on Certainty of "How-To" knowledge ($F = 6.20$, $df = 1, 344$, $p < .05$). Unfortunately, only a small proportion of the variance is accounted for in this case by the condition.

Table 6

Effect of Site Visit on Uncertainty of "How-to" Knowledge

	Mean Uncertainty			
	Experimental 2.96		Control 3.15	
Source	df	MS	F	p
Condition	1	2.555	6.200	$p < .05$
Hospital	22	.454	1.110	ns
Subject	322	.409		
*Pooled error	344	.412		
Total	345			

* = error term used to compute F ratio

2. Certainty of Effectiveness subscale - respondents answered these questions by indicating how certain they were that the Lodge was an effective program. The Site Visit had no effect on this (Table 7, $F = .004$, $df = 1, 22$, ns), although there was a significant difference between hospitals ($F = 1.86$, $df = 22, 339$, $p < .05$).

Table 7

Effect of Site Visit on Uncertainty of Effectiveness

	Mean Uncertainty			
	Experimental 2.70		Control 2.71	
Source	df	MS	F	p
Condition	1	.004	.004	ns
*Hospital	22	1.100	1.860	$p < .05$
Subject	339	.592		
Total	362			

* = error term used to compute F ratio

3. Certainty of Feasibility subscale - this subscale consisted of items asking about certainty that the program was feasible within the context of the respondent's hospital and community. There was no difference between either conditions ($F = 1.72$, $df = 1, 360$, ns, Table 8) or hospitals on this subscale ($F = 1.24$, $df = 22, 338$, ns).

4. Overall Certainty Scale - the Overall Certainty Scale was composed of the sum of the three subscales just described. As indicated by Table 9, the Site Visit did marginally reduce uncertainty about the program ($F = 3.23$, $df = 1, 22$, $p < .10$). There were also significant hospital differences ($F = 1.60$, $df = 22, 303$, $p < .05$).

As a summary of the results about uncertainty, it can be said that the Site Visit did have an effect on uncertainty, although more so for "How-To" uncertainty. This may give some indications of some of the strengths and weaknesses of the site visit technique.

Effects on boundary spanning. As noted in the first chapter, boundary-spanning or linkage with the external environment may be critical in the innovation process. The extent of boundary spanning was measured in three ways.

1. Telephone Calls to consultant - These were spontaneous calls to the consultant requesting some kind of information. Excluded from this count were calls having to do with the workshop, the site visit, or any other administrative matter. The actual measure used here is the number of hospitals that made such calls

Table 8

Effect of Site Visit on Uncertainty of Feasibility

	Mean Uncertainty			
	Experimental 3.37		Control 3.45	
Source	df	MS	F	p
Condition	1	.4802	1.751	ns
Hospital	22	.3397	1.238	ns
Subject	338	.2743		
*Pooled error	360	.2783		
Total	361			

* = error term used to compute F ratio

Table 9

Effect of Site Visit on Overall Uncertainty

	Mean Uncertainty			
	Experimental 2.94		Control 3.08	
Source	df	MS	F	p
Condition	1	1.238	3.230	$p < .10$
*Hospital	22	.383	1.597	$p < .05$
Subject	303	.240		
Total	326			$eta^2 = .015$

* = error term used to compute F ratio

in each condition. In other words, a hospital received a score of one (made one or more calls) or zero (made no calls) on this measure. As indicated by the Chi-Square table (Table 10), six hospitals in the Site Visit condition made calls to the consultant, while none did in the Control condition. This difference is significant ($X^2 = 5.55$, df = 1, $p < .02$).

2. Letters to consultant - This was similar to the telephone call measure. Again only letters to the consultant requesting information were used, as opposed to letters concerning such "administrative" matters as setting dates for site visits or consultation. Table 11 shows that seven site visit hospitals sent letters, while only three control hospitals did so. This difference is not significant ($X^2 = 1.54$, df = 1, ns).

3. Visits to other Institutions - Only included here are spontaneous visits to institutions that had a Lodge program, but excluding any visits to the original site visit hospital in Minnesota, or to another hospital that was included in the Site Visit condition. Table 12 shows that four site visit hospitals made such visits, while none of the control hospitals did so. This difference was not significant ($X^2 = 2.70$, df = 1, ns). It should be noted however, that one hospital in the site visit condition sent personnel to visit the hospital in Minnesota on a separate occasion. Also, one of the site visitors made a visit to another site visit hospital that was beginning to implement its own Lodge program. Another point of interest is that several of the site

Table 10

Effect of Site Visit on Calls to Consultant

	Site Visit	Control	Total
Made Calls	6	0	0
Made no Calls	6	12	18
Total	12	12	

$X^2 = 5.55$ $p < .05$

Table 11

Effect of Site Visit on Sending Letters to Consultant

	Site Visit	Control	Total
Sent Letters	7	3	10
Sent no Letters	5	9	14
Total	12	12	

$X^2 = 1.543$ ns

Table 12

Effect of Site Visit on Visits to Other Lodge Programs

	Site Visit	Control	Total
Made Visits	4	0	4
Made no Visits	8	12	20
Total	12	12	

$X^2 = 2.70$ ns

visitors made efforts on their own to disseminate information about the Lodge to local Community Mental Health Centers and other mental health agencies, while no such efforts were reported at the control hospitals.

Given the evidence that has just been presented, it can be stated that to some extent, the Site Visit seems to have increased the amount of boundary spanning or linkage that the hospitals had with their environment.

Effect on attitude. The Attitude Scale measured the respondents' agreement with the Lodge program's components and belief that it should be adopted by their hospitals. As Table 13 shows, the Site Visit had no effect on attitude toward the Lodge ($F = .310$, $df = 1, 22$), although there were significant hospital differences on this variable ($F = 2.05$, $df = 22, 273$, $p < .01$).

Effect on knowledge. The knowledge test consisted of items testing knowledge about a variety of aspects of the Lodge. Table 14 shows that there were no significant differences between either conditions ($F = .265$, $df = 1, 384$) or hospitals.

Effect on Movement Toward Adoption

The measure used to determine movement toward adoption was the Change Scale. Data for this was collected during the Telephone Follow-up calls. Thus there are measures for extent of adoption at 3, 6, 9, and 13 months after the workshop. The mean adoption level for each condition at each time period is shown in the graph

Table 13

Effect of Site Visit on
Attitude Toward Lodge

	Mean Attitude Score			
	Experimental 3.95		Control 3.90	
Source	df	MS	F	p
Condition	1	.157	.633	ns
*Hospital	22	.509	2.054	p < .005
Subjects	273	.248		
Total	296			

* = error term used to compute F ratio

Table 14

Effect of Site Visit on Knowledge
About Lodge

	Mean Knowledge Score			
	Site Visit 3.00		Control 3.06	
Source	df	MS	F	p
Conditions	1	.279	.265	ns
Hospitals	22	.735	.685	ns
Subjects	362	1.074		
*Pooled Error	384	1.054		
Total	385			

* = error term used to compute F ratio

in Figure 5. Table 15 shows that the differences apparent in the graph approach significance ($F = 2.86$, $df = 1, 22$, $p < .11$). This test was a repeated measures Analysis of Variance (Winter, 1976). A small, but substantial, portion of the variance in change score (6.3%) does seem to be accounted for by the Site Visit. Thus, there are indications that the Site Visit may have had a small impact on adoption of the Lodge over all four follow-up periods. The lack of significant effect for Time indicates that between three and thirteen months the level of adoption did not increase for the entire sample.

This completes the tests of the hypotheses described in Chapter 1. The Site Visit was shown to have significant effects on staff uncertainty concerning their knowledge about how to set up the Lodge program and on the extent of linkage the hospital had with its environment. There were also marginal effects on advocacy and adoption of the program. In addition to hypothesis testing there were a number of additional, post-hoc, tests that were performed on some additional variables.

Post-Hoc Tests

Post-hoc test of effect on locus of control. The Locus of Control Scale measured respondents' feelings about whether they or some external forces (e.g. hospital administrators) had major influence on their activities within the hospital and on hospital affairs. There were no differences between conditions on this scale (Table 16; $F = .59$, $df = 1, 22$), although there were significant hospital differences ($F = 1.78$, $df = 22, 333$, $p < .05$).

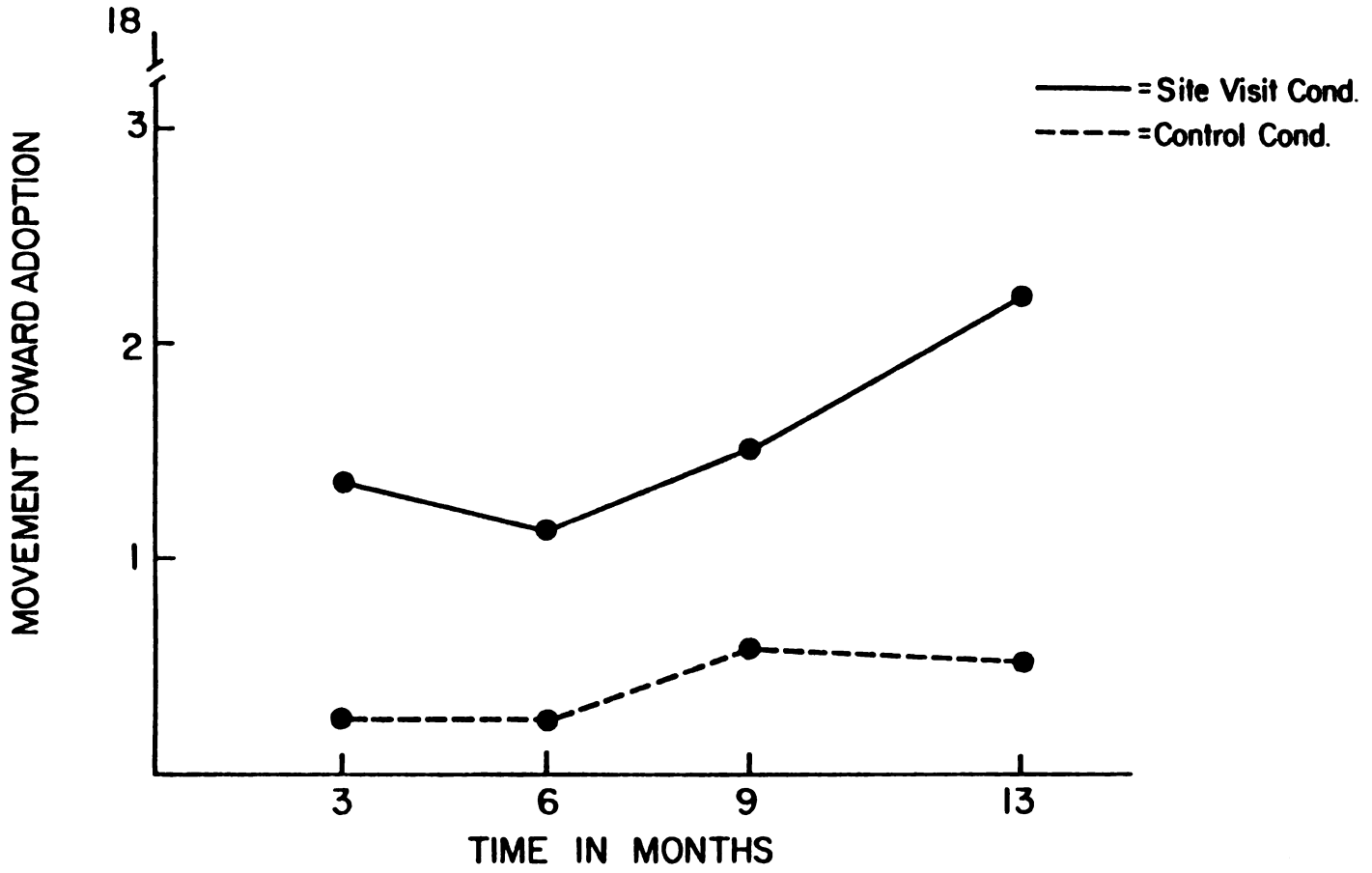

Figure 5

Movement Toward Adoption by Condition Over Time

Table 15

Movement Toward Adoption
by Condition

Source	df	MS	F	p
Conditions	1	30.083	2.858	$p < .11$
*Hospital	22	10.527		
Time	3	2.401	.767	ns
C x T	3	.801	.256	ns
*H x T	66	3.129		
Total	95			$eta^2 = .063$

* = error term used to compute F ratio

Table 16

Effect of Site Visit on Locus of Control

	Mean Degree of Internality (Higher is More Internal)			
	Site Visit 3.21		Control 3.13	
Source	df	MS	F	p
Conditions	1	.483	.590	ns
*Hospitals	22	.819	1.780	< .05
Subjects	333	.460		
Total	356			

* = error term used to compute F ratio

Post-hoc test on attitude and uncertainty. If in fact the reduction in uncertainty noted above was due to discussion and interaction with the Site Visitor (either directly or indirectly) then it would seem that the effect should be stronger for those people who interacted more with the visitor, or at least discussed the program more. Since no one in the control group had the opportunity to speak with a site visitor, the only comparison that can be made is between people who were more involved in discussion about the program. Thus, both groups were divided at the median on Question 2 of the Mail-Out Questionnaire, personal involvement in discussions about the program. A comparison was made between conditions for respondents above the median on that question.

Table 17 reveals that the Site Visit did have a highly significant effect for this group of people on their certainty of "How-To" knowledge ($F = 11.76$, $df = 1, 175$, $p < .001$). Note that this is a much stronger effect than was obtained for the entire sample (Table 6). Certainty of Effectiveness of the program was marginally enhanced by the Site Visit (Table 18; $F = 2.84$, $df = 1, 163$, $p < .10$), something that did not occur for the entire sample (Table 7). There was no effect on Certainty of Feasibility. The overall Certainty Scale shows a highly significant effect for the Site Visit (Table 19; $F = 11.05$, $df = 1, 148$, $p < .001$) similar to that for How-To Certainty. Finally, there are indications that the Site Visit may have affected attitudes that these people held about the program (Table 20; $F = 2.97$, $df = 1, 133$, $p < .10$), a result not found for the entire sample.

Table 17

"How-To" Knowledge
(above median on discussion)

	Experimental 2.72		Control 3.07	
Source	df	MS	F	p
Condition	1	4.012	11.76	p < .001
Hospitals	22	.211	.59	ns
Subjects	154	.360		
*Pooled Error	176	.341		
Total	177			eta^2 = .063

* = error term used to compute F ratio

Table 18

Effectiveness
(above median on discussion)

	Experimental 2.38		Control 2.59	
Source	df	MS	F	p
Condition	1	1.514	2.783	p < .10
Hospitals	22	.619	1.159	ns
Subjects	163	.534		
*Pooled Error	185	.544		
Total	186			eta^2 = .015

* = error term used to compute F ratio

Table 19

Overall Uncertainty
(above median on discussion)

Source	Experimental 2.72 df	MS	Control 2.99 F	p
Condition	1	2.403	11.17	$p < .001$
Hospitals	22	.192	.88	ns
Subjects	148	.218		
*Polled Error	170	.215		
Total	171			$eta^2 = .062$

* = error term used to compute F ratio

Table 20

Attitude Toward Lodge
(above median on discussion)

Source	Experimental 4.13 df	MS	Control 3.99 F	p
Condition	1	.643	2.937	$p < .10$
Hospitals	22	.239	1.103	ns
Subjects	133	.216		
*Pooled Error	155	.219		
Total	156			$eta^2 = .019$

* = error term used to compute F ratio

These data indicate that those people who were more involved in discussion concerning the Lodge program (and who were, presumably more interested in it) were more influenced by the Site Visit than were their less interested peers. The evidence that has been provided has shown that the Site Visit condition reduced uncertainty, increased advocacy and boundary spanning, and resulted in a trend toward greater movement toward adoption of the Lodge. In order to better understand the processes which took place that resulted in these findings some additional analyses were performed.

Effects of Similarity and Site Visitor Characteristics

Similarity. The Similarity Scale (Appendix W) was given to the Site Visitor as part of the questionnaire filled out at the conclusion of the Site Visit. It measured the extent to which the visitor perceived the Site Visit hospital as being similar to his or her own. One way to examine the similarity scores is to compare adopting versus non-adopting hospitals. In this case adopting hospitals were defined as those hospitals in the Site Visit condition that had made some movement toward adoption, and had not regressed, as of 13 months after the workshop. There were four "adopting" hospitals and eight "non-adopting" hospitals. A t-test comparing the two groups showed that the adopting hospitals perceived the visited hospital as significantly more similar than did the non-adopting hospitals ($t = 3.37$, $df = 12$, $p < .01$). This is confirmed by the correlation found between similarity and

adoption at 13 months, which was .697. Thus, perceived similarity would seem to be an important factor in the success of a Site Visit in increasing adoption of an innovation.

Site visitor characteristics. Correlations were computed to determine whether certain characteristics of the Site Visitors were related to adoption. The visitor's occupational area of training seems particularly important. Area of training (i.e. nursing, psychology, social work, etc.) can be considered to be a scale depending on the relative status of the discipline. Thus areas of training were ordered from one to five in the following order: aide, nurse, social worker or business, psychology, psychiatry (based on Tornatzky, et al., 1978). Area of training had a correlation of -.53 with adoption, thereby indicating that the less prestigeous the visitors' area of training, the more effective was the visit.

Questions were also asked of the Site Visitor asking whether he or she thought the Site Visit would be useful for him/herself or the hospital. Usefulness for self correlated .55 with adoption and usefulness for hospital correlated .62 with adoption. This would seem to indicate that the visitor left the visit with a fairly accurate idea about whether or not the innovation could be useful for his/her hospital.

Cluster Analysis

One technique that can be used to enhance understanding of the data that has been presented, particularly in terms of the

organization involved, is Cluster Analysis. The particular method of Cluster Analysis that was used in this study involved the BCTRY computer package as developed by Tryon and Bailey (1970). In addition to the usual breakdown of variables into clusters (cluster analysis of variables or "V" analysis), the BCTRY system allows the user to find respondent types based on standardized cluster scores. This can be of particular value in the present situation since the method, known as Cluster Analysis of Objects ("O" Analysis) could be used to find organizational types in such a manner as to possibly predict change.

The first step in the Cluster Analysis is the analysis of variables ("V" Analysis). The results of the V Analysis can be found in Table 21. The V Analysis was performed using the scales and individual items from the Mail-Out Questionnaire. The results indicate that there are two clusters of variables, an Attitude-Certainty cluster (which might be considered to be tapping some cognitive dimension concerning the Lodge) and a discussion cluster. The relationships between the clusters themselves and with the four change scores are shown in Table 22. The two clusters are clearly related. The discussion cluster is shown to be rather highly related to change, while the cognitive cluster is shown to be related, but less so.

The Cluster Analysis of Objects ("O" Analysis) revealed four "O" Types of hospitals. The standard scores of the O'Types on each of the clusters is presented in Figure 6. Basically the

Table 21

Cluster Analysis - Cluster Loadings

Cluster 1 - Discussion (Reliability = .862)	
Variable	Loading
1. Perceived Discussion (MOQ, Q1)	-1.000
2. Mean Discussion (MOQ, Q 33)	.767
3. Highest % of Vote for Advocate (MOQ, Q5)	.742
4. Mean Link Strength of Star (MOQ, Q 33)	.612
5. Personal Involvement in Discussion	.449
Cluster 2 - Certainty-Attitude (Reliability = .840)	
Variable	Loading
1. "How-To" Certainty Subscale	.838
2. Effectiveness Certainty Subscale	.837
3. Attitude Scale	.758
4. Feasibility Certainty Subscale	.507

Table 22

Correlations of Clusters to Change and Each Other

	Cluster 1	Cluster 2
Cluster 2 (Attitude-Certainty)	.406	
Change 3 months	.335	.176
Change 6 months	.430	.220
Change 9 months	.588	.487
Change 13 months	.397	.285

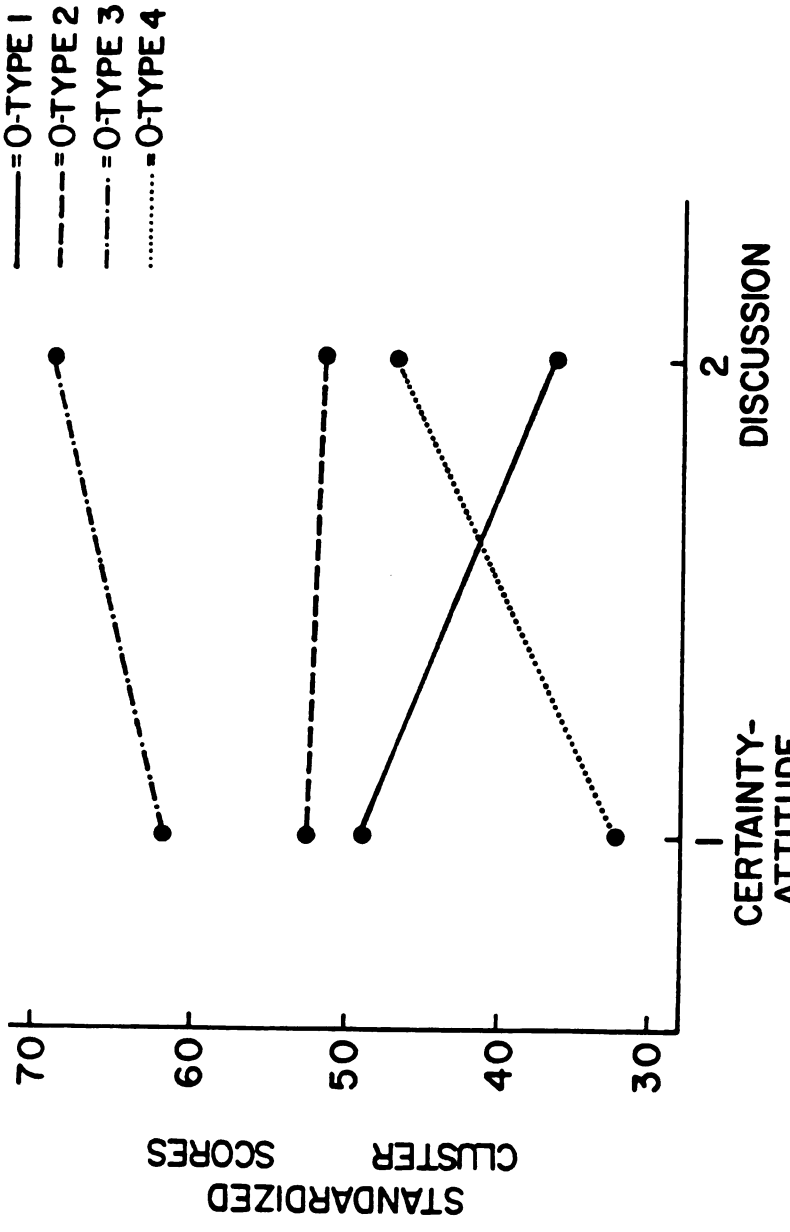

Figure 6

Cluster Scores of O-Types

Table 22a

Correlations of Variables in the Cluster Analysis with Change

Variables	Change at 13 Months
Knowledge	.113
How-To Certainty	.202
Effectiveness Certainty	.298
Feasibility Certainty	.163
Attitude	.176
Perceived Discussion	.328
% Naming Advocate	.177
Actual Mean Discussion	.335
Mean of Advocate	.493

four O-Types are: 1) O-Type 1 (6 hospitals) - average attitude-certainty, with very low discussion; 2) o-Type 2 (11 hospitals) - moderate attitude-certainty, with moderate discussion; 3) O-Type 3 (4 hospitals) - moderate to high attitude-certainty, with high discussion; and 4) O-Type 4 (3 hospitals) - very low attitude-certainty, with low discussion. Figure 7 depicts the mean movement toward adoption by each O-Type at each of the four follow-up periods. O-Type 3 is seen to have the greatest amount of change, O-Type 2 a somewhat lesser amount, and O-Types 1 and 4 essentially none. This would seem to confirm the notion, discussed earlier, that reduced uncertainty and increased discussion would lead to greater change. What is of particular interest is that <u>both</u> reduced uncertainty and increased discussion seem to be necessary for change to take place. However, while those are necessary for change, they are by no means sufficient. There were hospitals in both O-Types 2 and 3 that produced no change at all.

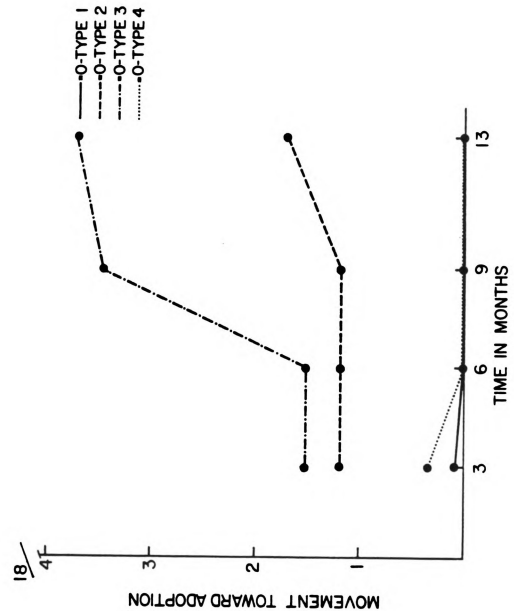

Figure 7

Movement Toward Adoption by O-Type Over Time

To conclude this chapter, one final test should be noted An overall test of significant was performed comparing experimental and control conditions on multiple dependent measures. These measures were a) the two cluster scores, b) the locus of control measure, and c) the knowledge test. The last two were included separately due to their being dropped from the cluster analysis. The multivariate F did not reach the .05 level of significance ($F = 2.46$, $df = 4, 19$, ns).

CHAPTER IV

DISCUSSION

Social Process

Perhaps the clearest findings of this study have to do with the way in which social processes within the hospitals were affected by the Site Visit. The uncertainty that hospital staff felt concerning the Community Lodge was reduced as a result of the Site Visit. This effect was particularly pronounced for the uncertainty the staff felt concerning their knowledge about how to set up the program. This may have indicated that the visit was perceived more as a "how-to-do it" lesson than as a means of providing evidence for the effectiveness or feasibility of the Lodge.

That there was no effect on uncertainty of feasibility is of considerable interest. On the one hand this seems to indicate that a Site Visit has no effect on this variable. On the other hand, combined with the finding that similarity increased the effectiveness of the intervention, it could simply mean that in many cases the visited hospital was not sufficiently similar to the visitors' hospitals for the visit there to be effective. In future research this could be corrected by attempting to match visiting and visited hospitals on a variety of characteristics, so that they would be perceived as being as similar as possible.

Another important result of the experiment was that boundary spanning activity (as measured by consultant contacts) was increased as a result of the Site Visit. This could indicate that boundary-spanning (in the form of a site visit) begets further boundary spanning. In other words, once someone has taken an initial step outside of his organization to investigate a new program, further outside steps are more likely to occur. Another, related explanation (at least for the difference between conditions on telephone calls) could be that the site visitor was more comfortable with the consultant as a result of the contacts made concerning administrative arrangements for the site visit. Thus he would be more likely to contact the consultant or recommend that others contact the consultant for information. Since these administrative contacts with the site visitor are an inevitable part of the site visit process there is no way to sort out their effects. Some indication of the importance of the visit itself in this process is given by the non-significant trend for the site visit hospital to make more visits to other institutions having Lodges. If this trend were supported by further research, it would provide stronger evidence that the visit itself was an important impetus for boundary spanning.

One additional finding in terms of process data is the marginally significant difference between the two conditions in the extent of advocacy taking place, as measured by the strength of communication with the sociometric "star" in the hospital. This is

an indication that communication patterns within the hospital were altered by the site visit, and that greater advocacy may have been taking place as a result.

It can be seen that the Site Visit intervention had generally the effects that were hypothesized on social process. However, these effects were considerably weaker than expected. The intervention reduced uncertainty about how to set up the innovation (although only to a very limited extent), but did not reduce uncertainty about the effectiveness or feasibility of the program. The site visit marginally increased advocacy, but did not increase discussion. Finally, the intervention increased some forms of boundary spanning, but not others. The expection was that if the site visit would affect social process in the ways hypothesized, then actual movement toward adoption of the Lodge would be enhanced.

Movement Toward Adoption

There were indications that approached significance ($p < .11$) that the Site Visit intervention may have increased movement toward adoption of the Community Lodge. Given the relative weakness of the social process findings, this outcome should not be surprising. Unfortunately, the interpretation of such results is rather difficult. A possible interpretation is that site visits do not affect innovation adoption. While this interpretation cannot be ruled out, it may be useful to explore alternative explanations of the results.

One explanation, that is on the order of an excuse, has to do with sample size. The sample used in this experiment was only

24, meaning that the effect of an experimental manipulation would have to be relatively strong in order to achieve statistical significance. That question unfortunately is moot, there being no way to determine what might have happened had a larger sample been used.

Another possible explanation has to do with what may have been the relative weakness of the intervention itself. Basically, this argument states that the specific intervention used in this experiment was not strong enough to provide an adequate test of the site visit concept. This may in fact have been the case. The intervention consisted of sending only one person, chosen almost at random (although presumably the selection was based to a great extent on interest in the program), out of a staff of many hundreds, on a visit of only two days to an institution that may or may not have had any similarity to the visitor's own institution. No consultation assistance was provided until after a major part of the program had already been set up.

Certainly this intervention could have been made stronger. More visitors from each hospital could have been sent, the visit could have been lengthened so as to include more content, or hospitals could have been matched so that visitor hospitals would be as similar as possible to the visited hospitals. While these changes in the intervention might theoretically make the Site Visit technique more effective, only further experimental work can determine <u>how much</u> more effective such changes would make it. Certainly there is a strong possibility that such incremental changes might have only the most minimal effect on outcome.

Another way of adding to the impact of the site visit intervention might be to alter the context in which it is placed. It may be the case that a site visit would be more effective if it were placed in a different position in the innovation adoption process. For example, the visit might have greater impact if it were placed after a specific decision had been made concerning Lodge adoption. In the case of the present experiment, the visit took place prior to any such decision. Another possibility is that a site visit might interact with other interventions to create a much stronger overall effect. This might be the case if consultation assistance were provided immediately after a site visit were completed, thereby reinforcing its content. In the present study, assistance was not provided until a considerable period of time had passed since the visit, possibly weakening its impact.

The problem of lack of consultation assistance brings up another point. The Site Visit intervention by itself, lacks an action component in that no attempt was made to directly "push" the hospital to do anything. As Fairweather, Sanders, and Tornatzky (1974) have shown, only action begets action. Further confirmation of this notion is provided by the strong negative correlation (-.53) between the status of the Site Visitor and change. One interpretation of this is that for lower level staff the Site Visit constitutes an action consultation (much as that defined by Fairweather, Sanders, and Tornatzky). This is because these staff would be in a position to directly and immediately implement what they had learned during

the Site Visit. On the other hand, higher status staff would need to make an additional connection to lower level staff in order for action to take place. This would clearly argue for only including lower level staff as future site visitors.

Factors Influencing Adoption

Some of the more interesting results of this study were derived from the Cluster Analysis that was performed on the data. That analysis showed that both increased discussion and reduced uncertainty were necessary for adoption of the Community Lodge to take place. Thus, in order to create organizational change, it is necessary to make changes in both individual attitudes and organizational process. However, while discussion and reduced uncertainty were necessary for change to occur, they were by no means sufficient. Other factors are therefore of great importance in the innovation adoption process.

One indication of the importance of at least one other factor can be found in the earlier diffusion study by Fairweather, Sanders, and Tornatzy (1974). They reported that participation in decision making seemed to be an essential factor for adoption to occur. This finding has been confirmed in a study reported by Fergus (1978). It would seem then, to be a fruitful tactic to combine a site visit, which would not be expected to affect participation in decision making, with some kind of intervention that does affect participation. Interventions that affect participation have been reported by Fergus

(1978) and by Avellar (1978). This is clearly related to the notion discussed earlier that the context in which an intervention is placed is of great importance. It should also be noted that while the interventions reported by Fergus and Avellar were effective, they were by no means overwhelming in their effect. The same can be said for the Site Visit intervention. Combining the two types of intervention might result in an interaction which could be quite powerful.

Hospital Factors

One finding that has not received much attention thus far is the result that there were significant differences between hospitals (as opposed to conditions) on a number of variables. This type of outcome has also been reported by Fergus (1978). What this finding means is that differences between organizations were more important determinants of those variables (e.g., Discussion, Table 2; Locus of Control, Table 11; Attitude toward Lodge, Table 10) than was the Site Visit intervention. Certainly then differences between organizations need to be taken into consideration when planning a dissemination intervention.

The exact way in which these differences between organizations can be utilized is as yet unclear. However, a recent paper by this author (Fleischer, 1978) and by Downs and Mohr (1976) have given some indications as to their use. If it were possible to systematize organizational differences that were related to innovation and change, then, using the O-Analysis procedure (Tyron & Baily, 1970) described

earlier, it should be possible to match change tactics to organizational type in such a way as to enhance the effectiveness of the tactics.

This can be extended using the "Innovation-Decision" concept of Downs and Mohr to the development of the organization-innovation combination types, each of which could be matched to different change tactics. As discussed by Fleischer (1978) this concept is just in the formative stages and requires considerable investigation before it becomes a practical tactic of use to change agents.

Summary

Probably the clearest point to be derived from this study is that there is a great need for further research into techniques for diffusing innovations to organizations. While the Site Visit technique in the present form and used in the context described is seen to be only marginally effective, there are indications that the technique could be of use in future dissemination efforts. What needs to be done is further research to determine if strengthening the technique makes it more powerful (and if the increase in power is worth the added expense), and whether altering the context in which the visit takes place has any effect on adoption. One set of techniques that would appear to have particular promise, based on the above discussion, would be to provide a workshop on the innovation, then provide a site visit, and finally immediately follow with a consultation assistance visit that included some kind of intervention designed to enhance participation on the part of staff. In

particular, this would provide some of the action aspects that were missing from the training provided in the present study. This set of techniques could be compared to other combinations of techniques in an experimental design.

APPENDICES

APPENDIX A

SAMPLE OF HOSPITALS

APPENDIX A

SAMPLE OF HOSPITALS

1.	Central State Hospital	-Indianapolis, Indiana
2.	Madison State Hospital	-Madison, Indiana
3.	Mental Health Institute	-Independence Iowa
4.	Newberry State Hospital	-Newberry, Michigan
5.	Traverse City State Hospital	-Traverse City, Michigan
6.	Ypsilanti State Hospital	-Ypsilanti, Michigan
7.	Fulton State Hospital	-Fulton, Missouri
8.	Rockland Psychiatric Center	-Orangeburg, New York
9.	Utica Psychiatric Center	-Utica, New York
10.	Embrieville State Hospital	-Embrieville, Pennsylvania
11.	Toledo Mental Health Center	-Toledo, Ohio
12.	Southwestern State Hospital	-Marion, Virginia
13.	Huntington State Hospital	-Huntington, West Virginia
14.	E. Moline State Hospital	-E. Moline, Illinois
15.	Elgin State Hospital	-Elgin, Illinois
16.	Kankakee State Hospital	-Kankakee, Illinois
17.	Tinley Park State Hospital	-Tinley Park, Illinois
18.	Evansville State Hospital	-Evansville, Indiana
19.	River Region State Hospital	-Louisville, Kentucky
20.	Western State Hospital	-Hopkinsville, Kentucky
21.	Larned State Hospital	-Larned, Kansas
22.	Osawatomie State Hospital	-Ossawatomie, Kentucky
23.	Springville Hospital Center	-Sykeville, Maryland
24.	Brooklyn State Hospital	-Brooklyn, New York
25.	Buffalo Psychiatric Center	-Buffalo, New York
26.	Marcy Psychiatric Center	-Marcy, New York
27.	Clark Summit State Hospital	-Clark Summit, Pennsylvania
28.	Haverford State Hospital	-Haverford, Pennsylvania
29.	Cambridge Hospital Center	-Cambridge, Ohio
30.	Lakin State Hospital	-Lakin, West Virginia
31.	Chicago-Read Mental Health Center	-Chicago, Illinois
32.	McFarland Mental Health Center	-Springfield, Illinois
33.	Beatty Memorial Hospital	-Westville, Indiana
34.	Kentucky State Hospital	-Danville, Kentucky
35.	Pontiac State Hospital	-Pontiac, Michigan
36.	St. Louis State Hospital	-St. Louis, Missouri

37.	Harrisburg State Hospital	-Harrisburg, Pennsylvania
38.	Woodville State Hospital	-Carnegie, Pennsylvania
39.	Somerset State Hospital	-Somerset, Pennsylvania
40.	Ancora Psychiatric Hospital	-Hammonton, New Jersey
41.	Greystone Park Psychiatric Hospital	-Greystone Park, New Jersey
42.	Marlboro Psychiatric Hospital	-Marlboro, New Jersey
43.	Torrance State Hospital	-Torrance, Pennsylvania
44.	Western State Hospital	-Staunton, Virginia

APPENDIX B

COVER LETTER TO SUPERINTENDENTS

MICHIGAN STATE UNIVERSITY

MSU-NIMH INNOVATION DIFFUSION PROJECT
DEPARTMENT OF PSYCHOLOGY
OLDS HALL

EAST LANSING • MICHIGAN • 48824

Recently our research group entered into an agreement with the National Institute of Mental Health to inform hospitals throughout the nation about an exemplary program for the treatment of mental patients. As part of this project we have agreed to provide training and consultation assistance to hospitals that might be interested in the treatment program. The training assistance consists of a one day workshop that we can present in your hospital at our expense. Should you be interested in adopting the program we can provide free consultation assistance to aid you toward this end. The enclosed brochure provides some general information about the program. We have provided a few additional copies for you to pass on to members of your staff that might be interested.

We will be contacting you by phone in the next few days to provide you with more detailed information about our project and to further explain the assistance we are offering. If you have any questions about this treatment program or about our project we will be happy to answer then when we call. We will look forward to speaking with you in a few days.

Sincerely,

Louis G. Tornatzky, Ph.D.
Co-principal Investigator
MSU-NIMH Innovation Diffusion Project

LGT/jc

Enclosure

APPENDIX C

2 - PHONE PROTOCOL - FIRST CALL TO SUPERINTENDENT

APPENDIX C

2 - PHONE PROTOCOL - FIRST CALL TO SUPERINTENDENT

Hello! This is Mitchell Fleischer from the Innovation Diffusion Project at Michigan State University. We wrote you about a week ago concerning a research project we are undertaking in conjunction with NIMH (response?). As you will recall, our research team has entered into an agreement with NIMH to inform hospitals throughout the nation about an exemplary treatment program for mental patients. This program is the Hospital-Community Treatment Program, as described in the brochure. You will recall that it is a rather unique program, and involves setting up a working and living situation for patients in the community. It has two innovative features: first, it is mainly set up and run by ex-patients themselves; and second, it is largely self-supporting. Research data demonstrate that most patients can live in such a community setting, that recidivism is greatly reduced, and that the cost of such a program is appreciably lower than hospitalization.

As I've already mentioned, we're involved in informing hospitals about this program. What this typically involves is our visiting a hospital and giving a one day workshop at our expense. The workshop includes a lecture, with a film and slide presentation,

and some group activities. There's also the possibility of sending one of your staff to visit the site of such a program.

We'd like to make arrangements for the workshop as soon as possible, but if you'd like to think about it more or would like to discuss it with your staff that's fine. We can recontact you by letter in a week or so. If you would like some more copies of the brochure for members of your staff to see, I can send some.

One other point is that if you do have the workshop, we'd like you to agree to permit one of your staff to make the site visit I mentioned. At this point do you have any (more) questions?

A. (if no questions) OK. Well, I'd just like to make sure I've got your address right. It's_____.

1. "Tell me more about this program." - Well, it first involves taking one ward in the hospital and dividing the patients into small, problem-solving groups. In these groups they begin to learn how to make realistic decisions about themselves and the others in their group. After the small groups have been together for a short while they are moved out into a community living situation, where they set themselves up in a business. In the beginning the patients are supervised fairly closely by the hospital staff, but after a while, as the patients learn to function more effectively, staff support is gradually withdrawn.

1a. "Tell me more about the site visits." - As I mentioned, we're as yet unsure that we will be able to provide this for your hospital. However, the visits will include meetings with both

staff and patients in the in-hospital SGW program, a visit to a lodge residence and the opportunity to watch the residents while they are at work. The visit will be for two days at a hospital in Minnesota. All travel expenses will be paid for.

2. "How will this obligate me or the hospital?" - As I mentioned before, this is part of a research effort in conjunction with NIMH. The only obligation is to have a workshop and for the staff at the workshop to complete two questionnaires. If, after the workshop, your hospital decides it would like to set up a Hoptical-Community Treatment Program, we will provide consultation assistance at no cost to the hospital, to help you do this.

3. Anything else - FAKE IT

4. "Isn't this the same as something we had running through here a few years ago by some obnoxious idiots?" - This is a similar program, but it's been changed considerably in order to make it more compatible with the systems used in most mental hospitals. Through these changes we hope to make it more useful to a greater range of hospitals.

APPENDIX D

REMINDER LETTER TO SUPERINTENDENT

MICHIGAN STATE UNIVERSITY

MSU-NIMH INNOVATION DIFFUSION PROJECT
DEPARTMENT OF PSYCHOLOGY
OLDS HALL

EAST LANSING • MICHIGAN • 48824

In our recent phone conversation concerning the Hospital-Community Treatment Program I mentioned that we would like to come to your hospital to give a one day workshop in order to more fully explain the program to you and your staff. After the workshop, if you should request it, we would provide consultation assistance to help you in implementing the treatment program. Both the workshop and the consultation will be provided at our expense. We would also like you to agree to permit one of your staff to visit (also at our expense) the site of a Hospital-Community Treatment Program should your hospital be chosen for this visit.

Please let us know whether you have decided to have the workshop or not. If you have decided to have the workshop, please indicate two or three convenient days and one of our staff will contact you to set a date.

Sincerely,

Mitchell Fleischer
Research Assistant
MSU-NIMH Innovation Diffusion Project

MF/jo

APPENDIX E

PROTOCOL #4 WORKSHOP DECISION FOLLOW-UP

APPENDIX E

PROTOCOL #4 WORKSHOP DECISION FOLLOW-UP

Hi. This is Dr._____ from the Innovation Diffusion Project. I spoke to you a few weeks ago about a hospital-community treatment program for mental patients that we're trying to inform mental hospitals about. Not long ago I sent you a brochure that told some details about the program and also a letter that asked if you would be interested in having a workshop at your hospital.

Have you come to any decision about whether you would like to have this workshop? (Ask only if respondent hasn't already volunteered this information.)

(if yes) - Do you also agree to allow one of your staff to visit the site of a hospital if the visit can be arranged? Could we set a date for the workshop?

(if no) - Could you tell me why you've come to this decision? (counter all arguments masterfully and convince him to have the workshop)

(if now decision yet) - Do you have any questions about the program? Can we call you back in a few days? (Set date) Well, if we don't hear from you within two weeks we'll assume that the answer is no.

APPENDIX F

WORKSHOP CONFIRMATION LETTER

MICHIGAN STATE UNIVERSITY

MSU-NIMH INNOVATION DIFFUSION PROJECT
DEPARTMENT OF PSYCHOLOGY
OLDS HALL

EAST LANSING • MICHIGAN • 48824

This is to confirm as the date we will be holding the Hospital-Community Treatment Program Workshop at your hospital. I will arrive at the hospital at approximately on to conduct the workshop. The workshop should last from about 9 a.m. till 4:00 a.m. The composition of the group will be at your discretion, but you might consider including the following: staff from discharge wards, staff from community mental health centers, representatives of the various services within the hospital, and administrative staff. I have enclosed a number of brochures for you to send around to those attending.

We will need the following equipment at the workshop: a 16mm sound projector, a 35mm slide projector, a screen, a large room for the morning and three adjacent rooms for the afternoon, and a microphone. If for some reason you will be unable to provide any of these items, please let us know right away. Thanks very much for your cooperation. I will look forward to meeting you.

Sincerely,

Mitchell Fleischer
Research Assistant
MSU-NIMH Innovation Diffusion Project

MF/jo

APPENDIX G

SCHEDULE FOR HOSPITAL-COMMUNITY TREATMENT PROGRAM WORKSHOP

APPENDIX G

SCHEDULE FOR HOSPITAL-COMMUNITY TREATMENT PROGRAM WORKSHOP

9:00 - 11:00	Presentation "Hospital-Community Treatment Program" Lecture with Slides Movie - "Some Kind of Magic Happens"
11:00 - 11:45	Discussion and Questions
11:45 - 1:00	Lunch
1:00 - 4:00	Presentation and Discussion "Establishing a SGW"

APPENDIX H

WORKSHOP QUESTIONNAIRE

WORKSHOP QUESTIONNAIRE

Below are some questions about yourself and the working situation in your hospital. Please answer each question by placing a check after the appropriate answer or by writing the answer in the space provided. This information will be used for research purposes only and will be kept in strictest confidence.

1. Name _____

2. Position (e.g., ward chief, staff nurse, chief of service) _____
_____

3. Area trained in (e.g., nursing, social work) _____

4. How long have you worked at this hospital?

less than 1 year	___1	
1-3 years	___2	
4-6 years	___3	
7-9 years	___4	1
10 or more years	___5	
I don't work at this hospital	___6	
(where do you work? _____)	___	

5. What is your highest education level?

some high school	___1	
high school graduate	___2	
some post-high school training	___3	
college graduate	___4	2
masters	___5	
doctorate (Ph.D. or M.D.)	___6	
	___	

6. What is your age? _____ 3-4

7. How many different professional journals or magazines related to your work do you usually read each month? _____ 5-6

8. How satisfied are you with your hospital's present program to help patients return to the community successfully?

very satisfied	___1	
somewhat satisfied	___2	
neither satisfied nor dissatisfied	___3	7
somewhat dissatisfied	___4	
very dissatisfied	___5	
	___	

9. Have you ever tried to set up a new program? 1___ yes 2___no 8

10. If "yes" to 9 - How successful were your attempts?

very successful	___1	
somewhat successful	___2	
neither successful nor unsuccessful	___3	9
somewhat successful	___4	
very unsuccessful	___5	
	___	

11. Did you get a chance to read the HCTP brochure prior to coming to this workshop? 1___yes 2___no 10

12. How much were you personally involved in the decision about whether or not to have this workshop?

completely involved	___1
moderately involved	___2
somewhat involved	___3
little involved	___4
not involved	___5

11

13. How much discussion was there about the workshop among the members of the hospital staff?

a great deal	___1
very much	___2
some	___3
little	___4
none	___5

12

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

elected or chosen as part of group decision	___1
volunteered or signed up	___2
appointed, assigned, designated	___3

13

15. Do you feel you know enough about how to set up a <u>small group ward</u> to be able to do it at your hospital?

definitely enough	___1
almost enough	___2
not sure	___3
probably not enough	___4
definitely not enough	___5

14

16. Do you feel you know enough about how to set up a <u>lodge</u> to be able to do it at your hospital?

definitely enough	___1
almost enough	___2
not sure	___3
probably not enough	___4
definitely not enough	___5

15

17. How much more do you feel you would need to know about the following aspects of the small group ward in order to set one up?

aspect of SGW	much more	some more	little more	no more	
a) step level system	___4	___3	___2	___1	16
b) note system	___4	___3	___2	___1	17
c) selection of patients	___4	___3	___2	___1	18
d) development of group cohesion and group work assignments	___4	___3	___2	___1	19

18. How much more do you feel you would need to know about the following aspects of the lodge program in order to set one up?

aspect of lodge	much more	some more	little more	no more	
a) starting the business & training the patients to work	4	3	2	1	20
b) obtaining funding	4	3	2	1	21
c) obtaining housing	4	3	2	1	22
d) lack of live in staff	4	3	2	1	23

19. How difficult do you think it would be to obtain funding to set up a HCTP at your hospital?

very easy	1	
somewhat easy	2	
somewhat difficult	3	24
very difficult	4	
impossible	5	

20. How difficult do you think it would be to obtain housing in the local community for a lodge?

very easy	1	
somewhat easy	2	
somewhat difficult	3	25
very difficult	4	
impossible	5	

21. How difficult do you think it would be for lodge members to establish their own business in the community?

very easy	1	
somewhat easy	2	
somewhat difficult	3	26
very difficult	4	
impossible	5	

22. How certain are you that the lodge could increase time spent out of the hospital for ex-patients from your hospital?

extremely certain	1	
very certain	2	
somewhat certain	3	27
slightly certain	4	
doubtful	5	

23. How certain are you that the lodge could increase employment for ex-patients from your hospital?

extremely certain	1	
very certain	2	
somewhat certain	3	28
slightly certain	4	
doubtful	5	

24. How certain are you that the small group ward could shorten the length of hospitalization for patients at your hospital?

extremely certain	___1	
very certain	___2	
somewhat certain	___3	29
slightly certain	___4	
doubtful	___5	

25. How certain are you that patient problems can be resolved on the small group ward using the note system?

extremely certain	___1	
very certain	___2	
somewhat certain	___3	30
slightly certain	___4	
doubtful	___5	

26. How certain are you that ex-mental patients can live in a lodge without live-in staff?

extremely certain	___1	
very certain	___2	
somewhat certain	___3	31
slightly certain	___4	
doubtful	___5	

27. This hospital should adopt the Hospital-Community Treatment Program (HCTP).

strongly agree	___1	
agree	___2	
neither agree nor disagree	___3	32
disagree	___4	
strongly disagree	___5	

28. My own philosophy of patient treatment is similar to the philosophy underlying the HCTP.

strongly agree	___1	
agree	___2	
neither agree nor disagree	___3	33
disagree	___4	
strongly disagree	___5	

29. Staff should allow patients to make decisions about how to handle daily problems on the ward, as is done in the HCTP.

strongly agree	___1	
agree	___2	
neither agree nor disagree	___3	34
disagree	___4	
strongly disagree	___5	

30. Staff should be willing to expose lodge members to real life situations where they might fail, as is done in the HCTP.

strongly agree	___1	
agree	___2	
neither agree nor disagree	___3	35
disagree	___4	
strongly disagree	___5	

31. Staff should be willing to have lodge members control their own living situation.

strongly agree	___1	
agree	___2	
neither agree nor disagree	___3	36
disagree	___4	
strongly disagree	___5	

32. Staff should be willing to have lodge members take responsibility for their own medications.

strongly agree	___1	
agree	___2	
neither agree nor disagree	___3	37
disagree	___4	
strongly disagree	___5	

33. Staff should be willing to help lodge members develop their own business.

strongly agree	___1	
agree	___2	
neither agree nor disagree	___3	38
disagree	___4	
strongly disagree	___5	

34. I intend to actively support the adoption of the HCTP.

strongly agree	___1	
agree	___2	
neither agree nor disagree	___3	39
disagree	___4	
strongly disagree	___5	

35. What specific action do you <u>intend</u> to take concerning this hospital's adoption of the HCTP? _____

_____

The following are a set of questions to find out the way in which events in hospitals such as yours affect different people. Each item consists of a statement followed by a set of alternative choices. Please <u>select the alternative you believe to be true by checking one choice for each item</u>. Be sure to select the one you <u>believe</u> to be true rather than the one you would like to be true. There are no right or wrong answers. Do not spend too much time on any one item. Be sure to answer <u>every</u> item. Try to respond to each item independently when making your choice; do not be influenced by your previous choice.

36. The average staff person can have an influence in hospital decisions.

strongly agree	___1	
agree	___2	
undecided	___3	40
disagree	___4	
strongly disagree	___5	

37. In the long run staff are responsible for bad programming in this hospital and other hospitals.

strongly agree	___1	
agree	___2	
undecided	___3	41
disagree	___4	
strongly disagree	___5	

38. Staff can control hospital affairs by taking an active part in them.

strongly agree	___1	
agree	___2	
undecided	___3	42
disagree	___4	
strongly disagree	___5	

39. Most of the time I can't understand why mental health administrators behave the way they do.

strongly agree	___1	
agree	___2	
undecided	___3	43
disagree	___4	
strongly disagree	___5	

40. With enough effort we can wipe out incompetent mental health programming.

strongly agree	___1	
agree	___2	
undecided	___3	44
disagree	___4	
strongly disagree	___5	

41. This hospital is run by the few people in power, and there is not much the little guy can do about it.

strongly agree	___1	
agree	___2	
undecided	___3	45
disagree	___4	
strongly disagree	___5	

42. It is difficult for staff to have much control over the things mental health administrators do in office.

strongly agree	___1	
agree	___2	
undecided	___3	46
disagree	___4	
strongly disagree	___5	

43. As far as hospital affairs are concerned, most of us are the victims of forces we can neither understand, nor control.

strongly agree	___1	
agree	___2	
undecided	___3	47
disagree	___4	
strongly disagree	___5	

The next few questions are designed to test the effectiveness of this workshop in imparting certain information about the Hospital-Community Treatment Program. Please place a check beside the best answer.

44. Which group of patients would be the poorest risk for the Hospital-Community Treatment Program?
___1 all chronics
___2 all alcoholics
___3 all "revolving door" acute schizophrenics
___4 a mixture of all of the above

48

45. What would be the best way to go about getting work for lodge members?
___1 Go to the State Employment Office for individual placement.
___2 Find placements in a sheltered workshop.
___3 Start a business for all lodge members to work in.
___4 Let the members find work on their own.

49

46. What is the best kind of location for a lodge residence?
___1 cottage on the hospital grounds
___2 middle class neighborhood
___3 "transitional-poor" neighborhood
___4 modern suburban neighborhood

50

47. A staff member on the Small Group Ward Program sees one of the patients sleeping in the dayroom when he is supposed to be performing his work assignment. What action should the staff member take?
___1 wake the patient up and tell him to go to work
___2 write a note and put it in the appropriate group's box
___3 tell the appropriate group leader
___4 the staff member should take no action

51

48. On the Small Group Ward Program what should be the limits of staff presence at the patient group meetings?
___1 Staff should never be present at the meetings.
___2 At least one staff member should always be present.
___3 Staff should be available to provide factual information, but should not attend the meeting otherwise.
___4 Staff should be available to provide solutions to problems that patients are unable to solve by themselves, but should not attend the meetings otherwise.

52

DO NOT WRITE BELOW THIS LINE

P		/_/	72
T		/_/	73
C		/_/	74
S	/_/	/_/	75-76
H	/_/	/_/	77-78
ID	/_/	/_/	79-80

APPENDIX I

SITE VISIT LETTER

MICHIGAN STATE UNIVERSITY

MSU-NIMH INNOVATION DIFFUSION PROJECT
DEPARTMENT OF PSYCHOLOGY
OLDS HALL

EAST LANSING · MICHIGAN · 48824

This is to confirm and as the dates you will be making the site visit to the Hospital-Community Treatment Program at Anoka State Hospital in Minnesota. The visit will be conducted by Mrs. Dorothy Berger, who is the director of the Fairweather program at Anoka. During your visit you will have the opportunity to watch the small group ward in action. You will also go out to a lodge residence and visit with lodge members while they are at work. There will be ample opportunity to discuss the program with the staff of both the Small Group Ward and Tasks Unlimited, the non-profit corporation which runs the lodges at Anoka.

Let me now provide you with the details about where you will stay and how you can be reimbursed for your expenses. I suggest that you fly into Minneaspolis-St. Paul the night before the visit. If you are driving, try to arrive the evening before. You will not be met at the airport. Take a limo or taxi to the following hotel:

A reservation has been made in your name. Mrs. Berger will meet you at the hotel in the morning. She will call the evening before to let you know the time. She will also arrange for all your transportation while you are on the visit. The second night will be spent at another hotel in Anoka. Again arrangements have been made for this. When you make your flight arrangements, have your return flight late in the afternoon or in the evening of the second day.

Here is a summary of the expenses you can be reimbursed for:

1. Direct round trip transportation from your home to Minneapolis. However, we cannot pay an amount greater than round-trip airfare plus ground connecticns.
2. Room for two nights.
3. Meals for two full days, plus the evening meal for your first night. This is reimbursed at the rate of $11.00 per day. The evening meal is allowed $6.00.

When you complete your travel please fill out the enclosed form and return it with the original receipts from your airplane and hotels. No receipts are necessary for meals. Be sure to sign the form. You must send us these receipts in order to be reimbursed.

I hope that your visit to Anoka State Hospital will be both pleasant and informative. If for some reason you will be unable to make the visit on these dates, let me know right away. We may be able to make other arrangements. If you have any questions concerning your visit, please feel free to call me at (517) 355-2145 or Mrs. Berger at (612) 421-3940.

Sincerely,

Mitchell Fleischer
Research Assistant
MSU-NIMH Innovation Diffusion Project

MF/jc

Enclosure

APPENDIX J

SAMPLE SITE VISIT SCHEDULE

APPENDIX J

SAMPLE SITE VISIT SCHEDULE

THE PROGRAM WILL CONSISTS OF:		TIME
	TUESDAY	
1.	Pick-up at Hotel at 7:00 a.m.	7:00
2.	Observation of Group III at work	8:30 9:00
3.	Overview of Program by Program Director. Slide show, discussion with nursing staff of self medication, work training methods on the ward, note-writing procedure, evaluations, admission and referral.	9:00 12:00
4.	LUNCH	12:00 1:00
5.	Role of County Welfare Department in community lodge program	1:00 1:30
6.	Evaluation for Group II	1:30 2:30
7.	Drive to Lodges: visit	2:30 3:15
8.	Spotless Lodge	3:15 4:15
9.	Drive to work place	4:15 5:00
10.	Visit Spotless work place	5:00 5:45
11.	Return to Hotel	5:45

WEDNESDAY

1.	Pick-up at Hotel	7:00
2.	Observe self-medication	7:30
3.	Observe bed check and note writing	8:00
4.	Visit work of Group II in dining room	8:30 9:00
5.	Job procurement	9:00 9:45
6.	Statistical results of lodge program	9:45 10:30
7.	Funding a lodge program	10:30 12:00
8.	LUNCH	12:00 1:00
9.	Development of Lodge Life: Medication Clinic, Recreation, Group Needs, Community Participation	1:30 2:30
10.	Depending on plane time: visit to another lodge or question-time as desired by visitors.	

APPENDIX K

SITE VISITOR QUESTIONNAIRE

SITE VISITOR QUESTIONNAIRE

Name _____

Hospital _____

1. What is the title of your position in the hospital? (e.g., Ward Chief, Staff Nurse, etc.) _____

2. What is your area of training? (e.g., Social Work, Psychology, etc.)

_____

3. How were you selected to be the one to make this site visit?
   1 elected or chosen as part of group decision
   2 volunteered or signed up 1
   3 appointed, assigned, designated

4. How similar do you think Anoka State Hospital is to your own hospital as regards patient population?
   1 very similar
   2 somewhat similar
   3 neither similar nor dissimilar 2
   4 somewhat dissimilar
   5 very dissimilar

5. How similar do you think Anoka SH is to your own hospital as regards quality of staff?
   1 very similar
   2 somewhat similar
   3 neither similar nor dissimilar 3
   4 somewhat dissimilar
   5 very dissimilar

6. How similar do you think Anoka SH is to your own hospital as regards financial resources?
   1 very similar
   2 somewhat similar
   3 neither similar nor dissimilar 4
   4 somewhat dissimilar
   5 very dissimilar

7. How similar do you think Anoka SH is to your own hospital as regards administrative cooperation with a program such as the Hospital-Community Treatment Program?
   1 very similar
   2 somewhat similar
   3 neither similar nor dissimilar 5
   4 somewhat dissimilar
   5 very dissimilar

8. How similar do you think Anoka SH is to your own hospital as regards community willingness to support a program like the Hospital-Community Treatment Program?
   ___1 very similar
   ___2 somewhat similar
   ___3 neither similar nor dissimilar 6
   ___4 somewhat dissimilar
   ___5 very dissimilar

9. How similar do you think Anoka SH is to your own hospital as regards physical plant?
   ___1 very similar
   ___2 somewhat similar
   ___3 neither similar nor dissimilar 7
   ___4 somewhat dissimilar
   ___5 very dissimilar

10. How similar do you think Anoka SH is to your own hospital as regards staff enthusiasm for programs like the Hospital Community Treatment Program?
   ___1 very similar
   ___2 somewhat similar
   ___3 neither similar nor dissimilar 8
   ___4 somewhat dissimilar
   ___5 very dissimilar

11. Do you intend to take any action in support of your hospital's adoption of the Hospital Community Treatment Program when you return?
   ___1 yes ___2 no 9

12. If YES to 11 - What specific actions do you intend to take? _____
   _____

13. What is your opinion of the usefulness of the site visit for yourself?
   ___1 extremely useful
   ___2 very useful
   ___3 somewhat useful 10
   ___4 somewhat useless
   ___5 very useless

14. What is your opinion of the usefulness of the site visit for your hospital?
   ___1 extremely useful
   ___2 very useful
   ___3 somewhat useful 11
   ___4 somewhat useless
   ___5 very useless

Please comment on the effectiveness of the site visit you have just made. Use as much space as you like.

15. Did you see and learn everything that you wanted to? _____

_____

16. Was there anything missing that would have made it more effective? _____

_____

17. What was unnecessary or redundant? _____

_____

18. Please describe any events or personalities that stood out during your visit. We are particularly interested in your interactions with your fellow visitors and the staff from Anoka or Tasks Unlimited. Use as much space as you need.

APPENDIX L

MAIL OUT QUESTIONNAIRE AND COVER LETTER

MICHIGAN STATE UNIVERSITY

MSU-NIMH INNOVATION DIFFUSION PROJECT
DEPARTMENT OF PSYCHOLOGY
OLDS HALL

EAST LANSING • MICHIGAN • 48824

I hope that you found the workshop we gave a few months ago on the Hospital-Community Treatment Program both informative and useful. I mentioned during that workshop that we would be sending you a questionnaire to fill out. Some of these questions are very similar to those you answered during the workshop, while others are very different. One of the things we are trying to determine is whether any changes have taken place in your opinions since the workshop. Please take the few minutes necessary to fill out the enclosed questionnaire and return it to us in the self-addressed envelope. Your assistance is greatly appreciated. Thank you.

Sincerely,

Mitchell Fleischer
Research Assistant
MSU-NIMH Innovation Diffusion Project

MF/jo

MAIL-OUT QUESTIONNAIRE

Below are some questions about yourself and the working situation at your hospital. Please answer each question by placing a check after the appropriate answer or by writing the answer in the space provided. This information will be used for research purposes only and will be kept in strictest confidence.

Name _____

Hospital _____

1. Since the workshop, how much discussion about the Hospital-Community Treatment Program has there been among the members of the hospital staff?
   ___1 a great deal
   ___2 very much
(1) ___3 some
   ___4 little
   ___5 none

2. How much were you personally involved in further discussion concerning the Hospital-Community Treatment Program?
   ___1 completely involved
   ___2 moderately involved
(2) ___3 somewhat involved
   ___4 little involved
   ___5 not involved

3. How satisfied are you with your hospital's actions to date concerning the Hospital-Community Treatment Program?
   ___1 very satisfied
   ___2 somewhat satisfied
(3) ___3 neither satisfied nor dissatisfied
   ___4 somewhat dissatisfied
   ___5 very dissatisfied

4. Regardless of what you think will happen, do you think your hospital <u>should</u> adopt the Hospital-Community Treatment Program?
   ___1 definitely
   ___2 probably
(4) ___3 not sure
   ___4 probably not
   ___5 definitely not

5. Is there any member of the hospital staff who has acted as a strong advocate for this hospital's adoption of the Hospital-Community Treatment Program?
   ___1 yes (What is his or her name and position in the hospital?
(5) _____)
   ___2 no

This next series of questions concerns some of your attitudes toward some aspects of the Hospital-Community Treatment Program and your hospital. Please answer them without regard to any action your hospital may have taken concerning the Hospital-Community Treatment Program.

6. Staff should allow patients to make decisions about how to handle daily problems on the ward as is done in the Hospital-Community Treatment Program.
   1 strongly agree
   2 agree
(6) 3 neither agree nor disagree
   4 disagree
   5 strongly disagree

7. Staff should be willing to expose lodge members to real life situations where they might fail.
   1 strongly agree
   2 agree
(7) 3 neither agree nor disagree
   4 disagree
   5 strongly disagree

8. Staff should be willing to have lodge members control their own living situation.
   1 strongly agree
   2 agree
(8) 3 neither agree nor disagree
   4 disagree
   5 strongly disagree

9. Staff should be willing to have lodge members take responsibility for their own medications.
   1 strongly agree
   2 agree
(9) 3 neither agree nor disagree
   4 disagree
   5 strongly disagree

10. Staff should be willing to help lodge members develop their own business.
   1 strongly agree
   2 agree
(10) 3 neither agree nor disagree
   4 disagree
   5 strongly disagree

11. My own philosophy of patient treatment is similar to the philosophy underlying the Hospital-Community Treatment Program.
   1 strongly agree
   2 agree
(11) 3 neither agree nor disagree
   4 disagree
   5 strongly disagree

12. How difficult do you think it would be to obtain funding to set up a Hospital-Community Treatment Program at your hospital?
   1 very easy
   2 somewhat easy
(12) 3 somewhat difficult
   4 very difficult
   5 impossible

13. How difficult do you think it would be to obtain housing in the local community for a lodge?
   1 very easy
   2 somewhat easy
(13) 3 somewhat difficult
   4 very difficult
   5 impossible

14. How difficult do you think it would be for lodge members to establish their own business in the community?
   1 very easy
   2 somewhat easy
(14) 3 somewhat difficult
   4 very difficult
   5 impossible

15. How certain are you that the lodge could increase time spent out of the hospital for ex-patients from your hospital?
   1 extremely certain
   2 very certain
(15) 3 somewhat certain
   4 slightly certain
   5 doubtful

16. How certain are you that the lodge could increase employment for expatients from your hospital?
   1 extremely certain
   2 very certain
(16) 3 somewhat certain
   4 slightly certain
   5 doubtful

17. How certain are you that the small group ward program could shorten the length of hospitalization for patients at your hospital?
   1 extremely certain
   2 very certain
(17) 3 somewhat certain
   4 slightly certain
   5 doubtful

18. How certain are you that ex-mental patients can live in a lodge without live-in staff?
   1 extremely certain
   2 very certain
(18) 3 somewhat certain
   4 slightly certain
   5 doubtful

19. How certain are you that patient problems can be resolved on the small group ward using the note system?

1 extremely certain
2 very certain
(19) 3 somewhat certain
4 slightly certain
5 doubtful

20. Do you feel you know enough about the small group ward to be able to do it at your hospital?

1 definitely enough
2 almost enough
(20) 3 not sure
4 probably not enough
5 definitely not enough

21. Do you feel you know enough about the lodge to be able to set one up at your hospital?

1 definitely enough
2 almost enough
(21) 3 not sure
4 probably not enough
5 definitely not enough

22. How much more do you feel you would need to know about the following aspects of the small group ward in order to set one up?

	much more	some more	little more	no more	aspect of Small Group Ward
(22)	4	3	2	1	a) step level system
(23)	4	3	2	1	b) note system
(24)	4	3	2	1	c) selection of patients
					d) development of group cohesion & group work
(25)	4	3	2	1	assignments

23. How much more do you feel you would need to know about the following aspects of the lodge program in order to set one up?

	much more	some more	little more	no more	aspect of Lodge
(26)	4	3	2	1	a) starting the business and training the patients to work
(27)	4	3	2	1	b) obtaining funding
(28)	4	3	2	1	c) obtaining housing
(29)	4	3	2	1	d) lack of live-in staff

The next few questions are designed to determine how much you remember about certain aspects of the Hospital-Community Treatment Program that were described during the workshop.

24. On the Small Group Ward Program what should be the limits of staff presence at the patient group meetings?

(30)
1 Staff should never be present at the meetings.
2 At least one staff member should always be present.
3 Staff should be available to provide factual information, but should not attend the meetings otherwise.
4 Staff should be available to provide solutions to problems that the patients are unable to solve by themselves, but should not attend meetings otherwise.

25. A staff member on the Small Group Ward Program sees one of the patients sleeping in the dayroom when he is supposed to be performing his work assignment. What action should the staff member take?

(31)
1 Wake the patient up and tell him to go to work.
2 Write a note and put it in the appropriate group's box.
3 Tell the appropriate group leader.
4 The staff member should take no action.

26. Which group of patients would be the poorest risk for the Hospital-Community Treatment Program?

(32)
1 all chronics
2 all alcoholics
3 all "revolving door" acute schizophrenics
4 a mixture of all of the above

27. What is the best kind of location for a lodge residence?

(33)
1 cottage on the hospital grounds
2 middle class neighborhood
3 "transitional-poor" neighborhood
4 modern suburban neighborhood

28. What would be the best way to go about getting work for lodge members?

(34)
1 Go to the State Employment Office for individual placement.
2 Find placements in a sheltered workshop.
3 Start a business for all lodge members to work in.
4 Let the members find work on their own.

The following are a set of questions to find out the way in which events in hospitals such as yours affect different people. Each item consists of a statement followed by a set of alternative choices. Please select the alternative you believe to be true by checking one choice for each item. Be sure to select the one you believe to be true rather than the one you would like to be true. There are no right or wrong answers. Do not spend too much time on any one item. Be sure to answer every item. Try to respond to each item independently when making your choice; do not be influenced by your previous choice.

29. The average staff person can have an influence in hospital decisions.

(35)
1 strongly agree
2 agree
3 undecided
4 disagree
5 strongly disagree

30. In the long run staff are responsible for bad programming in this hospital and other hospitals.
__1__ strongly agree
__2__ agree
(36) __3__ undecided
__4__ disagree
__5__ strongly disagree

31. Staff can control hospital affairs by taking an active part in them.
__1__ strongly agree
__2__ agree
(37) __3__ undecided
__4__ disagree
__5__ strongly disagree

32. Most of the time I can't understand why mental health administrators behave the way they do.
__1__ strongly agree
__2__ agree
(38) __3__ undecided
__4__ disagree
__5__ strongly disagree

33. With enough effort we can wipe out incompetent mental health programming.
__1__ strongly agree
__2__ agree
(39) __3__ undecided
__4__ disagree
__5__ strongly disagree

34. This hospital is run by the few people in power, and there is not much the little guy can do about it.
__1__ strongly agree
__2__ agree
(40) __3__ undecided
__4__ disagree
__5__ strongly disagree

35. It is difficult for staff to have much control over the things mental health administrators do in office.
__1__ strongly agree
__2__ agree
(41) __3__ undecided
__4__ disagree
__5__ strongly disagree

36. As far as hospital affairs are concerned, most of us are the victims of forces we can neither understand, nor control.
__1__ strongly agree
__2__ agree
(42) __3__ undecided
__4__ disagree
__5__ strongly disagree

33. **This question refers to the group of staff who have been involved with the Innovation Diffusion Project since our initial contact with your hospital. Please place a check beside <u>every</u> name in the box that indicates the amount of discussion concerning the Hospital-Community Treatment Program you have had with that individual <u>since the workshop</u>. If there are other individuals with whom you have discussed the program please fill in their names and indicate the amount of discussion you've had with them.**

Name	None	Little	Some	Much	A Great Deal
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
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	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5
	☐1	☐2	☐3	☐4	☐5

As you probably know one of the members of your hospital's staff made a visit to Anoka State Hospital in Minnesota, the site of an ongoing Hospital-Community Treatment Program. The next few questions refer to your contacts with that individual.

37. How much information have you received concerning the visit to Anoka State Hospital?

___ a great deal
(43) ___ some
___ little
___ none

38. How often have you had contact with the person who made the visit, since he or she returned from Minnesota?

___ daily contact
___ one or more times per week
(44) ___ occasionally
___ one or two times since the visit
___ no contact

39. How would you rate the site visitor as concerns his or her knowledge about the Hospital-Community Treatment Program?

___ extremely knowledgeable
___ very knowledgeable
(45) ___ somewhat knowledgeable
___ slightly knowledgeable
___ not very knowledgeable
___ I have no idea, I have had no contact

DO NOT WRITE BELOW THIS LINE

74 C ☐
75-76 S ☐☐
77-78 H ☐☐
79-80 ID ☐☐

APPENDIX M

FOLLOW-UP LETTER

MICHIGAN STATE UNIVERSITY

MSU-NIMH INNOVATION DIFFUSION PROJECT
DEPARTMENT OF PSYCHOLOGY
OLDS HALL

EAST LANSING · MICHIGAN · 48824

We recently sent you a questionnaire concerning the Hospital-Community Treatment Program. The information to be gathered from that questionnaire will be extremely important since it represents the hospital staff point of view. This is needed to balance the "researcher bias" that is so prevalent in many research studies. We have enclosed another copy of the questionnaire. Please fill it out and return it in the attached envelope. Thank you very much for your cooperation.

Sincerely,

Louis G. Tornatzky, Ph.D.
Co-principal Investigator
MSU-NIMH Innovation Diffusion Project

LGT/jo

Enclosure

APPENDIX N

PHONE FOLLOW-UP QUESTIONS

Respondent _____	Interviewer _____
Hospital _____	Date of on Site Consultation _____
Follow up Call # (Circle one) 1 2 3 4	Date of this call _____

Follow-up Calls (I)

(Interviewer)

Call every 45 days after completion of 1st consultation. After 6 months past the date of on site consultation, stop all calls.

(Interviewer)

(After 1st call) If answer to Q1 yes, say "Do the staff still meet regularly to discuss plans for implementing the SGW program?" If answer to Q1 no, then read Q1 as written below.

1. Are there staff who meet regularly to discuss plans for implementing the small group ward program?

   Yes 2 (go to 2)
   No 1 (go to 7) 1

2. Who are they? Please give their names. _____

   _____

   _____

   _____

   _____

   _____

   _____

   (Interviewer)

   After 1st call say: "In our last call you gave me names of staff who are involved in implementing the small group ward program. Are there any staff names that should be added or deleted?"

3. How many times have these people met to discuss the program? 2-3

(Interviewer)

After 1st call say: "How many times have these people met to discuss the program since the last consultation call?"

2

4. Are these meetings regular staff meetings or are they meetings only to discuss the implementation of the small group ward?

Yes
No 4

5. What percent of the people you mentioned before attend these meetings almost all of the time?

76-100% 5
51-75% 4
26-50% 3 5
1-25% 2
0% 1

6. What percent of the people you mentioned before would you say work in the same ward or area?

76-100% 5
51-75% 4
26-50% 3 6
1-25% 2
0% 1

At this time I'd like to see how far you have moved toward accomplishing specific tasks to establish the small group ward program.

(Interviewer)

After 1st call don't ask questions 7- if answered yes. Say "In the last call a ward had already been selected, etc. _____ since then has staff been assigned to work on the ward? etc. _____(Reiterate what had been done and ask what more has been done since the last call.)

7. Is the small group ward program now operating?

Yes (Go to page 4)
No (Go to 9) 7

9. Has a ward been selected?

Yes
No 11

10. Have staff been assigned to work on the ward?

Yes
No 12

3

11. Have patients been assigned to groups?

Yes
No 15

12. Has a step-level-reward system been established?

Yes
No 18

13. Have group work assignments been arranged?

Yes
No 21

14. Has a daily ward schedule been developed?

Yes
No 24

15. Have the necessary forms for the program been completed?

Yes
No 25

16. (a) Has the hospital-at-large hindered the development of the ward program in any way?

Yes
No 26

(b) If Yes, explain:

17. Is there any future plan to implement the small group ward program?

Yes (Go to a)
No (Go to c) 27

(a) How soon do you think this will happen?

within a month 5
2-3 months 4
4-5 months 3
5-6 months 2
more than 6 months 1

(b) Why is there a delay?

(Interviewer)

End

(c) Why did the hospital decide to drop the program?

End

8. How long has the small group ward program been operating in its present form? _____ days 8-10

9. Has a ward been selected?

Yes 11
No

10. Have staff been assigned to work on the ward?

Yes (Go to 11)
No 12

a. Have all the staff members been participating in the staff evaluations of the patients?

Yes
No 13

b. In its evaluations and decisions have the staff considered the groups' performance rather than individual performances?

Yes
No 14

11. Have patients been assigned to groups?

Yes (Go to 12)
No 15

a. Have the patient groups organized themselves well enough to handle the problems presented to them?

Yes
No 16

b. In their daily meetings do the patient groups meet without staff present?

Yes
No 17

12. Has a step-level-reward system been established?

Yes (Go to 13)
No 18

a. Are staff satisfied with how the step-level-reward system is working?

Yes
No 19

Why or why not?

b. Is the step-level-reward system used to shape patient group behavior?

Yes
No 20

13. Have group work assignments been arranged?

Yes (Go to 14)
No 21

a. Are the patients working together as groups in their work assignments?

Yes
No 22

b. Have the groups been allowed to function autonomously in the work assignments?

Yes
No 23

14. Has a daily ward schedule been developed?

Yes
No 24

15. Have the necessary forms for the program been completed?

Yes
No 25

16. (a) Has the hospital-at-large hindered the development of the ward program in any way?

Yes
No 26

(b) If Yes, explain:

(Interviewer)

End of formal data gathering

(Interviewer)

Use responses to the questions above to focus on problems they need to resolve. End the telephone conversation with "Do you feel ready to receive the 2nd consultation?"

17. Do you feel ready to receive the 2nd consultation?

Respondent _____ Interviewer _____

Hospital _____ Date of on Site Consultation _____

Follow-up Call # (Circle one) 1 2 3 4 5 6 7 8 9 Date of Call _____

Follow-up Calls (II, III)

(Call every 45 days after completion of 2nd Consultation)

1. Are there staff who meet regularly to discuss plans for implementing the lodge program?

   Yes 2 (go to 2)
   No 1 (go to 6) 1

2. Here's a list of people who were present at the last consultation. Have any people been added or deleted from your group?

Interviewer

After 1st call following Consultation II, say: "In our previous call you gave me names of staff who are involved in implementing the lodge program. Are there any staff names that should be added or deleted?"

_____
_____
_____
_____
_____
_____
_____

3. How many times have these people met to discuss the program since the last Consultation (or call)? 2-3

4. What percent of the people you mentioned before attend these meetings almost all of the time?

   76-100% 5
   51-75% 4
   26-50% 3
   1-25% 2
   0% 1 4

5. What percent of the staff would you say work in the same ward or area?

   76-100% 5
   51-75% 4
   26-50% 3
   1-25% 2
   0% 1 5

Interviewer

Now I would like to ask you questions about how far you and your staff have been able to complete tasks for implementing the lodge.

6. Patient Development. Has anything been done by the patients to prepare themselves for the move into the community

(a) Have the residents met to discuss plans for the lodge?
Yes ___ 2
No ___ 1 6

(b) Have they made any decisions about their living arrangements in the lodge?
Yes ___ 2
No ___ 1 7

(c) Have decisions been made about assigning roles to lodge members such as cook, crew chief, etc.?
Yes ___ 2
No ___ 1 8

7. Staff. Has anything been done about staff coverage in the lodge?

(a) Has a lodge coordinator been assigned?
Yes ___ 2
No ___ 1 9

Who is it?

(b) Has a system been established for the coordinator to communicate with the hospital staff?
Yes ___ 2
No ___ 1 10

8. Housing. Has anything been done towards establishing housing for the residents?

(a) Has a building for the lodge been found in the community?
Yes ___ 2
No ___ 1 11

(b) Has the financing for the housing been resolved?
Yes ___ 2
No ___ 1 12

8. (c) Has furnishings been obtained for the lodge?

Yes ___ 2
No ___ 1 13

(d) What type of residence is it? What is the socio-economic status of the community where the lodge will be located?

9. Living Situation. Has anything been done on living arrangements in the community for the lodge residents?

(a) Have arrangements been made for residents to receive medication in the community?

Yes ___ 2
No ___ 1 14

(b) Has a system been formulated for how food will be purchased and prepared?

Yes ___ 2
No ___ 1 15

(c) Has a system been formulated for how laundry will be done?

Yes ___ 2
No ___ 1 16

(d) Has a system for staff coverage been developed for lodge residents during hours that the coordinator is off duty?

Yes ___ 2
No ___ 1 17

(e) Have arrangements been made for transportation?

Yes ___ 2
No ___ 1 18

10. Business. How much has been accomplished in the way of securing and running a business?

(a) Has a business been selected?

Yes ___ 2
No ___ 1 (go to 11) 19

10. (b) What kind of work will they do?

(c) Has the lodge coordinator been trained in that particular business?

Yes ___ 2
No ___ 1 20

(d) Have patients been trained in the necessary skills for the business?

Yes ___ 2
No ___ 1 21

(e) Has any plan been made about how quality of work will be monitored?

Yes ___ 2
No ___ 1 22

(f) Has necessary equipment been obtained for their work?

Yes ___ 2
No ___ 1 23

(g) Has insurance been secured?

Yes ___ 2
No ___ 1 24

(h) Have bonding arrangements been made for the residents?

Yes ___ 2
No ___ 1 25

(i) Has a decision been made about how the income from their work will be divided?

Yes ___ 2
No ___ 1 26

(j) Will the residents work in crews?

Yes ___ 2
No ___ 1 27

(k) Have residents gone out on any actual jobs in the community?

Yes ___ 2
No ___ 1 28

11. Legal. Has a non-profit corporation or other legal entity been established?

Yes ___ 2
No ___ 1 29

If yes, could you describe the type of legal entity?

Do you have a Board?

Yes ___ 2
No ___ 1 30

Who sits on the Board? What type of expertise do they have?

Has a decision been reached about the legal status of residents in the lodge?

Yes ___ 2
No ___ 1 31

If yes, what is it?

Since the last Consultation (or call) have you had contact with any other hospitals concerning the Hospital-Community Treatment Program?

Yes ___ 2
No ___ 1 32

APPENDIX O

COMMUNICATION NETWORK ITEMS

33. This question refers to the group of staff who have been involved with the Innovation Diffusion Project since our initial contact with your hospital. Please place a check beside <u>every</u> name in the box that indicates the amount of discussion concerning the Hospital-Community Treatment Program you have had with that individual <u>since the workshop</u>. If there are other individuals with whom you have discussed the program please fill in their names and indicate the amount of discussion you've had with them.

Name	None	Little	Some	Much	A Great Deal
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
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	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
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	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

APPENDIX P

OVERALL CERTAINTY SCALE

APPENDIX P

OVERALL CERTAINTY SCALE

1. Do you feel you know enough about how to set up a small group ward to be able to do it at your hospital?

definitely enough	___1
almost enough	___2
not sure	___3
probably not enough	___4
definitely not enough	___5

2. Do you feel you know enough about how to set up a lodge to be able to do it at your hospital?

definitely enough	___1
almost enough	___2
not sure	___3
probably not enough	___4
definitely not enough	___5

3. How much more do you feel you would need to know about the following aspects of the small group ward in order to set one up?

aspect of SGW	much more	some more	little more	no more
a) step level system	___4	___3	___2	___1
b) note system	___4	___3	___2	___1
c) selection of patients	___4	___3	___2	___1
d) development of group cohesion and group work assignments	___4	___3	___2	___1

4. How certain are you that the small group ward could shorten the length of hospitalization for patients at your hospital?

extermely certain	___1
very certain	___2
somewhat certain	___3
slightly certain	___4
doubtful	___5

5. How certain are you that patient problems can be resolved on the small group ward using the note system?

extremely certain	___1
very certain	___2
somewhat certain	___3
slightly certain	___4
doubtful	___5

6. How certain are you that ex-mental patients can live in a lodge without live-in staff?

extremely certain	___1
very certain	___2
somewhat certain	___3
slightly certain	___4
doubtful	___5

7. How much more do you feel you would need to know about the following aspects of the lodge program in order to set one up?

aspect of lodge	much more	some more	little more	no more
a) starting the business & training the patients to work	___4	___3	___2	___1
b) obtaining funding	___4	___3	___2	___1
c) obtaining housing	___4	___3	___2	___1
d) lack of live in staff	___4	___3	___2	___1

8. How difficult do you think it would be to obtain funding to set up a HCTP at your hospital?

very easy	___1
somewhat easy	___2
somewhat difficult	___3
very difficult	___4
impossible	___5

9. How difficult do you think it would be to obtain housing in the local community for a lodge?

very easy	___1
somewhat easy	___2
somewhat difficult	___3
very difficult	___4
impossible	___5

10. How difficult do you think it would be for lodge members to establish their own business in the community?

very easy	___1
somewhat easy	___2
somewhat difficult	___3
very difficult	___4
impossible	___5

11. How certain are you that the lodge could increase time spent out of the hospital for ex-patients from your hospital?

extremely certain	___1
very certain	___2
somewhat certain	___3
slightly certain	___4
doubtful	___5

12. How certain are you that the lodge could increase employment for ex-patients from your hospital?

extremely certain	___1
very certain	___2
somewhat certain	___3
slightly certain	___4
doubtful	___5

APPENDIX Q

CERTAINTY OF HOW-TO KNOWLEDGE SUBSCALE

APPENDIX Q

CERTAINTY OF HOW-TO KNOWLEDGE SUBSCALE

1. Do you feel you know enough about how to set up a small group ward to be able to do it at your hospital?

definitely	___1
almost enough	___2
not sure	___3
probably not enough	___4
definitely not enough	___5

2. Do you feel you know enough about how to set up a lodge to be able to do it at your hospital?

definitely enough	___1
almost enough	___2
not sure	___3
probably not enough	___4
definitely not enough	___5

3. How much more do you feel you would need to know about the following aspects of the small group ward in order to set one up?

aspect of SGW	much more	some more	little more	no more
a) step level system	___4	___3	___2	___1
b) note system	___4	___3	___2	___1
c) selection of patients	___4	___3	___2	___1
d) development of group cohension and group work assignments	___4	___3	___2	___1

4. How much more do you feel you would need to know about the following aspects of the lodge program in order to set one up?

aspect of lodge	much more	some more	little more	no more
a) starting the business & training the patients to work	___4	___3	___2	___1
b) obtaining the funding	___4	___3	___2	___1
c) obtaining housing	___4	___3	___2	___1
d) lack of live in staff	___4	___3	___2	___1

APPENDIX R

CERTAINTY OF EFFECTIVENESS SUBSCALE

APPENDIX R

CERTAINTY OF EFFECTIVENESS SUBSCALE

1. How certain are you that the small group ward could shorten the length of hospitalization for patients at your hospital?

extremely certain	___1
very certain	___2
somewhat certain	___3
slightly certain	___4
doubtful	___5

2. How certain are you that patient problems can be resolved on the small group ward using the note system?

extremely certain	___1
very certain	___2
somewhat certain	___3
slightly certain	___4
doubtful	___5

3. How certain are you that ex-mental patients can live in a lodge without live-in staff?

extremely certain	___1
very certain	___2
somewhat certain	___3
slightly certain	___4
doubtful	___5

4. How certain are you that the lodge could increase time spent out of the hospital for ex-patients from your hospital?

extremely certain	___1
very certain	___2
somewhat certain	___3
slightly certain	___4
doubtful	___5

5. How certain are you that the lodge could increase employment for ex-patients from your hospital?

extremely certain	___1
very certain	___2
somewhat certain	___3
slightly certain	___4
doubtful	___5

APPENDIX S

CERTAINTY OF FEASIBILITY SUBSCALE

APPENDIX S

CERTAINTY OF FEASIBILITY SUBSCALE

1. How difficult do you think it would be to obtain funding to set up a HCTP at your hospital?

very easy	___1
somewhat easy	___2
somewhat difficult	___3
very difficult	___4
impossible	___5

2. How difficult do you think it would be to obtain housing in the local community for a lodge?

very easy	___1
somewhat easy	___2
somewhat difficult	___3
very difficult	___4
impossible	___5

3. How difficult do you think it would be for lodge members to establish their own business in the community?

very easy	___1
somewhat easy	___2
somewhat difficult	___3
very difficult	___4
impossible	___5

APPENDIX T

ATTITUDE SCALE

APPENDIX T

ATTITUDE SCALE

1. This hospital should adopt the Hospital-Community Treatment Program (HCTP).
   - strongly agree ___1
   - agree ___2
   - neither agree nor disagree ___3
   - disagree ___4
   - strongly disagree ___5

2. My own philsophy of patient treatment is simlar to the philosophy underlying the HCTP.
   - strongly agree ___1
   - agree ___2
   - neither agree nor disagree ___3
   - disagree ___4
   - strongly disagree ___5

3. Staff should allow patients to make decisions about how to handle daily problems on the ward, as is done in the HCTP.
   - strongly agree ___1
   - agree ___2
   - neither agree nor disagree ___3
   - disagree ___4
   - strongly disagree ___5

4. Staff should be willing to expose lodge members to real life situations where they might fail, as is done in the HCTP.
   - strongly agree ___1
   - agree ___2
   - neither agree nor disagree ___3
   - disagree ___4
   - strongly disagree ___5

5. Staff should be willing to have lodge members control their own living situations.
   - strongly agree ___1
   - agree ___2
   - neither agree nor disagree ___3
   - disagree ___4
   - strongly disagree ___5

6. Staff should be willing to have lodge members take responsibility for their own medications.

strongly agree	___1
agree	___2
neither agree nor disagree	___3
disagree	___4
strongly disagree	___5

7. Staff should be willing to help lodge members develop their own business.

strongly agree	___1
agree	___2
neither agree nor disagree	___3
disagree	___4
strongly disagree	___5

8. I intend to actively support the adoption of the HCTP.

strongly agree	___1
agree	___2
neither agree nor disagree	___3
disagree	___4
strongly disagree	___5

APPENDIX U

KNOWLEDGE TEST

APPENDIX U

KNOWLEDGE TEST

1. What would be the best way to go about getting work for lodge members?

___1 Go to the State Employment Office for individual placement.
___2 Find placements in a sheltered workshop.
___3 Start a business for all lodge members to work in.
___4 Let the members find work on their own.

2. What is the best kind of location for a lodge residence?

___1 cottage on the hospital grounds
___2 middle class neighborhood
___3 "transitional-poor" neighborhood
___4 modern suburban neighborhood

3. A staff member on the Small Group Ward Program sees one of the patients sleeping in the dayroom when he is suppoed to be performing his work assignment. What action should the staff member take?

___1 wake the patient up and tell him to go to work
___2 write a note and put it in the appropriate group's box
___3 tell the appropriate group leader
___4 the staff member should take no action

4. On the Small Group Ward Program what should be the limits of staff presence at the patient group meetings?

___1 Staff should never be present at the meetings.
___2 At least one staff member should always be present. Staff should be available to provide factual information, but should not attend the meeting otherwise.
___3 Staff should be available to provide solutions to problems that patients are unable to solve by themselves, but should not attend the meetings.
___4 Otherwise.

APPENDIX V

CHANGE SCALE

APPENDIX V

CHANGE SCALE

A. Small Group Ward Items

1. Select a Ward
2. Assign Staff to ward
3. Assign patients to groups
4. Establish Step-Level reward system
5. Arrange Group Work assignments
6. Develop daily ward schedule
7. Complete forms necessary for program

B. Community Lodge Items

1. Residents meet to discuss plans
2. Residents make decisions about living arrangements
3. Assign roles to members
4. Assign Lodge coordinator
5. Establish communication system between Lodge & Hospital
6. Find housing
7. Find financing for hoursing
8. Obtain furnishings
9. Arrange for medications in community
10. System for food purchase & preparation
11. System for laundry
12. System for staff coverage
13. Arrangements for transportation
14. Select a business
15. Train Lodge coordinator in the business
16. Train residents
17. Develop plan for monitoring work
18. Obtain equipment
19. Secure insurance
20. Arrange for bonding
21. Decide how income will be divided
22. Decide whether work will be done in crews
23. Go out on a real job
24. Establish legal entity
25. Decide on legal status of residents
26. Choose Board of Directors

APPENDIX W

INTERNAL-EXTERNAL LOCUS OF CONTROL SCALE

APPENDIX W

INTERNAL-EXTERNAL LOCUS OF CONTROL SCALE

1. The average staff person can have an influence in hospital decisions.

strongly agree	___1
agree	___2
undecided	___3
disagree	___4
strongly disagree	___5

2. In the long run staff are responsible for bad programming in this hospital and other hospitals.

strongly agree	___1
agree	___2
undecided	___3
disagree	___4
strongly disagree	___5

3. Staff can control hospital affairs by taking an active part in them.

strongly agree	___1
agree	___2
undecided	___3
disagree	___4
strongly disagree	___5

4. Most of the time I can't understand why mental health administrators behave the way they do.

strongly agree	___1
agree	___2
undecided	___3
disagree	___4
strongly disagree	___5

5. With enough effort we can wipe out incompetent mental health programming.

strongly agree	___1
agree	___2
undecided	___3
disagree	___4
strongly disagree	___5

6. This hospital is run by the few people in power, and there is not much the little guy can do about it.

strongly agree	___1
agree	___2
undecided	___3
disagree	___4
strongly disagree	___5

7. It is difficult for staff to have much control over the things mental health administrators do in office.

strongly agree	___1
agree	___2
undecided	___3
disagree	___4
strongly disagree	___5

8. As far as hospital affairs are concerned, most of us are the victims of forces we can neither understand, nor control.

strongly agree	___1
agree	___2
undecided	___3
disagree	___4
strongly disagree	___5

APPENDIX X

SIMILARITY SCALE

APPENDIX X

SIMILARITY SCALE

1. How similar do you think Anoka SH is to your own hospital as regards community willingness to support a program like the Hospital-Community Treatment Program?

   ___1 very similar
   ___2 somewhat similar
   ___3 neither similar nor dissimilar
   ___4 somewhat dissimilar
   ___5 very dissimilar

2. How similar do you think Anoka SH is to your own hospital as regards physical plant?

   ___1 very similar
   ___2 somewhat similar
   ___3 neither similar nor dissimilar
   ___4 somewhat dissimilar
   ___5 very dissimilar

3. How similar do you think Anoka SH is to your own hospital as regards staff enthusiasm for programs like the Hospital Community Treatment Program?

   ___1 very similar
   ___2 somewhat similar
   ___3 neither similar nor dissimilar
   ___4 somewhat dissimilar
   ___5 very dissimilar

4. How similar do you think Anoka State Hospital is to your own hospital as regards patient population?

   ___1 very similar
   ___2 somewhat similar
   ___3 neither similar nor dissimilar
   ___4 somewhat dissimilar
   ___5 very dissimilar

5. How similar do you think Anoka SH is to your own hospital as regards quality of staff?

___1 very similar
___2 somewhat similar
___3 neither similar nor dissimilar
___4 somewhat dissimilar
___5 very dissimilar

6. How similar do you think Anoka SH is to your own hospital as regards financial resources?

___1 very similar
___2 somewhat similar
___3 neither similar nor dissimilar
___4 somewhat dissimilar
___5 very dissimilar

7. How similar do you think Anoka SH is to your own hospital as regards administrative cooperation with a program such as the Hospital-Community Treatment Program?

___1 very similar
___2 somewhat similar
___3 neither similar nor dissimilar
___4 somewhat dissimilar
___5 very dissimilar

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