Order Number 9431253

Configurations of family support services in Michigan: Organizational, contextual, and attitudinal influences

Hazel, Kelly Lee, Ph.D.

Michigan State University, 1994

U·M·I
300 N. Zeeb Rd.
Ann Arbor, MI 48106

CONFIGURATIONS OF FAMILY SUPPORT SERVICES IN MICHIGAN: ORGANIZATIONAL, CONTEXTUAL, AND ATTITUDINAL INFLUENCES

By

Kelly L. Hazel

A DISSERTATION

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

DOCTOR OF PHILOSOPHY

Department of Psychology

1994

ABSTRACT

CONFIGURATIONS OF FAMILY SUPPORT SERVICES IN MICHIGAN: ORGANIZATIONAL, CONTEXTUAL, AND ATTITUDINAL INFLUENCES

By

Kelly L. Hazel

Examined the implementation of family support services in Michigan, and tested the hypothesis that both characteristics of the organization and its context, as well as attitudes and beliefs of agency personnel (stakeholders) would be predictive of implementation. A mail survey, sent to 55 mental health agencies, assessed stakeholders' (N = 339) attitudes toward family support, their perceptions of forces which encourage or inhibit implementation, their decision making status, and what family support services were provided at their agency. Information regarding agency size, and service area population, density, wealth and demand for services was obtained from secondary data sources. A Michigan Department of Mental Health study provided data concerning the level of administrative formalization of family support at each agency and corroborative information regarding the number of services provided.

First-order correlations, corrected for attenuation, showed that organization and service area characteristics (r = .23 to .46), and attitudes of stakeholders (aggregated to the agency level) toward family support (r = .34 to .41) were significantly associated with the number of services but not formalization. Only stakeholders' perceptions of forces which inhibit or encourage family support were significantly associated with both number of services (r = .60) and formalization (r = .34 to .49).

Although the decision making status of the stakeholders was correlated with their attitudes and perceptions (r = .13 to .56), contrary to expectations, there was no evidence that status moderated the effects of individual characteristics on the criteria. Multiple regression analyses revealed that attitudes/perceptions (R = .69; uniqueness = .27) were more predictive of the number of services than were context characteristics (R = .48; uniqueness = .08). Only perceptions were predictive of formalization (R = .69).

Causal models, based on reasoned action and field theories, were tested using ordinary least squares path analysis. Consistent with expected mediation effects, attitudes toward family support predicted preferences for expansion/improvement of services (β = .76), which in turn predicted the number of services (β = .21). Also, perceptions of community support predicted agency commitment (β = .73), which in turn predicted the number of services (β = .43). Context characteristics were significant predictors of the number of services (β = .42), but not administrative formalization. Stakeholder perceptions of community (β = .62) and administrative support for services (β = .36) predicted agency commitment, which in turn predicted formalization (β = .50).

To the women in my life

who have made my success possible

Thank-you

ACKNOWLEDGMENTS

I would like to thank my committee members, Dr. Frank J. Floyd (chair), Dr. Esther O. Fergus, Dr. Sandra E. Herman, Dr. Ralph L. Levine, and Dr. William S. Davidson, III, for their help and support. I would especially like to acknowledge the contributions of my dissertation committee chairperson, Dr. Frank J. Floyd. His advice and consistent encouragement were extremely helpful in the birth process, which took significantly longer than I anticipated. Thank you, Frank, for empathizing with my frustrations and pushing me to get beyond my insecurities so that I may achieve my life's goals. I would also like to thank Dr. Sandra E. Herman for her steadfast support and belief in my abilities, and her suggestion that I stake out a section of the Department of Mental Health study, of which she was the principal investigator, for my dissertation research. Thanks also to my colleagues at the Michigan Department of Mental Health for seven years of collaborative work experience in program and policy evaluation. This research was sponsored, in part, by a grant from the Michigan Developmental Disabilities Council, whose foresight and innovative policies have encouraged and nurtured the expansion of family support services in Michigan. Thank-you all.

TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

TABLE OF CONTENTS (continued)

LIST OF TABLES

LIST OF TABLES (continued)

LIST OF FIGURES

CHAPTER 1

Introduction

Implementation is the installation of new policies or practices in public and private organizations (Yin, 1982). Research focusing on implementation has attempted to document the results of policy changes and determine factors that affect the outcomes of the implementation process (Hasenfeld & Brock, 1991; Ingram & Mann, 1980; Majone & Wildavsky, 1978; Mazmanian & Sabatier, 1981; McLaughlin, 1987; Sabatier, 1987a; Scheirer, 1981). A common theme in the literature is that the implementation of innovative policies is often frustrated by individual and organizational resistance and, consequently, organizations do not always implement policies as intended (Alexander, 1985; Bardach, 1977; Blakely, Mayer, Gottschalk, et al., 1987; Elmore, 1979, 1985; Fairweather & Tornatzky, 1977; Hasenfeld & Brock, 1991; Johnson & O'Connor, 1979; Kirst & Jung, 1980; McLaughlin, 1987; Sabatier, 1987b). Research has shown that variations in policy wording and content, technical requirements of proposed changes, control and flow of resources, incentives, organizational structures, and bureaucratic politics have produced wide variations in the implementation of proposed changes (Attewell & Gerstein, 1979; Downs, 1976; Edwards, 1980; Mazmanian & Sabatier, 1981, 1983; Van Meter & Van Horn, 1975).

Theory and research has stressed the role of individuals responsible for implementing changes both during the policy's framing (Sabatier, 1987a) and its implementation at the local level (Browning, Marshall & Tabb, 1981; McLaughlin, 1987). It has been argued that a human service agency's 'ideological bent' has important implications for the type and

diversity of services it implements (Frank & Davidson, 1983). In effect, it is not the organizations that innovate or implement change, it's the individuals in the organizations (McLaughlin, 1987). Research on policy implementation (Berman & McLaughlin, 1978; Browning, Marshall & Tabb, 1981; McLaughlin, 1987; Sabatier, 1987a; Scheirer, 1981) and on innovation diffusion (Backer, Liberman & Kuehnel, 1986; Fairweather, Sanders & Tornatzky, 1974; Glaser, Abelson & Garrison, 1983; Rogers, 1983) has shown that the results of implementation are to a large extent dependent upon the skills, attitudes, and behaviors of the individuals responsible at various levels in the implementing system.

Recently, innovative ways have been proposed for providing public support to families caring at home for their family member who has a developmental disability. Research has documented a wide diversity in local agency responses to these proposed changes in public support services for families (Agosta, Jennings & Bradley, 1985; Castellani, Downey, Tausig & Bird, 1986; Herman & Hazel, 1987, 1991; Herman, Thompson, Linklater & Hazel, 1992; Ireys, Hauck & Perrin, 1985; Knoll, Covert, Osuch, et al., 1990; Weiss, 1989). Variations in local responses to family support have been related to resources, incentives, and size and administrative structure of implementing organizations (Castellani et al., 1986; Herman & Hazel, 1991; Ireys et al., 1985). Yet, none of the studies have systematically examined the attitudes and beliefs of the individuals responsible for implementing family support programs at the local level. Nor, has previous research evaluated the extent to which these individual characteristics explain variations in the implementation of family support services.

This research was geared toward filling that gap. As part of a larger project evaluating the implementation of family support services in Michigan (Herman, Thompson et al., 1992), attitudes and beliefs of local agency personnel were examined in order to determine the extent to which these factors explain observed variations in family support services. In general, this study evaluated the hypothesis that organizational performance is determined

by structural characteristics of the organization and the context in which it operates, and by characteristics of organization personnel.

Historical Background

Traditionally, services for persons with developmental disabilities have focused on the habilitation of the individual with handicaps. Acceptance of the principles of normalization and the right of people with developmental disabilities to live and work in the least restrictive environment prompted changes in the service delivery system from institutional based care to community and family based care (Landesman & Butterfield, 1987; Sigelman, Roeder & Sigelman, 1981). However, the reduction of institutional placements and increased discharges to the community which were fostered by policies on deinstitutionalization were not balanced by a comparable expansion of community residential settings and support services (Moroney, 1986). In effect, the implementation of these policy changes challenged families to marshal the stamina, resources, and will to raise and nurture a family member with a handicap (Agosta & Bradley, 1985; Moroney, 1979, 1986; Seltzer & Krauss, 1984).

Families caring for members who are developmentally disabled confront challenges and bear burdens unknown to other families. Among the challenges that parents of children with disabilities face are the shock of the initial diagnosis and the consequent search for understanding and information, the exhausting nature of specialized care and training, family tensions aggravated by the fatigue of specialized care, and worries about the well-being of siblings and the future well-being of the child with a disability (Agosta & Bradley, 1985; Blacher, 1984; Seligman, 1983; Singer & Irvin, 1989). Other challenges include persistent financial concerns related to the specialized care of the child with disabilities, unpredictable crises, and the family's consequent involvement with an often unresponsive, inefficient, uncoordinated, and dehumanized service system (Agosta & Bradley, 1985; Blacher, 1984; Bruininks & Krantz, 1979; Gallagher & Vietze, 1986; Singer & Irvin, 1989; Slater & Wikler, 1986). These factors may produce stresses with which many

families find it difficult to cope. Research suggests that families with members who have a developmental disability, compared with other families, are likely to experience emotional and physical stress, social isolation, reduced autonomy, and extraordinary financial, time, and energy demands (Beckman, 1983; Blacher, 1984; Breslau & Prabucki, 1987; Cavanagh & Ashman, 1985; Chetwynd, 1985; Gallagher & Vietze, 1986; Gallagher, Beckman & Cross, 1983; Kazak, 1987; McKinney & Peterson, 1987; Quine & Pahl, 1985; Seligman, 1983; Sherman & Cocozza, 1984; Wikler, 1986).

Many factors determine the problems individual families may experience and the degree to which they are able to adjust to their situation. These factors include the seriousness of the family member's disability, the family's social and economic resources, and their capacity for coping with adversity (Blacher, 1984; Gallagher & Vietze, 1986; Singer & Irvin, 1989). Research has also shown that formal and informal supports available to families can increase their capacity to cope with the various demands and stresses (Agosta, 1989; Cohen, Agosta, Cohen & Warren, 1989; Dunst, Trivette & Deal, 1988; Gallagher, Beckman & Cross, 1983; Perlman & Giele, 1983; Rowitz, 1985; Sherman & Cocozza, 1984; Singer & Irvin, 1989; Summers, Behr & Turnbull, 1989; Tausig, 1988). Social and community supports can help normalize the family environment and help to reduce the stress experienced by families, thereby increasing their capacity to cope. The support of relatives, friends, service providers, and the community can further help by enabling and empowering families in their care giving roles (Dunst, Trivette & Deal, 1988; Dunst, Trivette, Gordon & Pletcher, 1989).

For example, respite care (the provision of periodic, temporary relief of care giving by sitters, in-home care workers, or a care agency) is seen as an essential part of the overall support that families may need to keep their child with a disability at home (Cernoch, 1989; Salisbury & Intagliata, 1986). Research has found that respite care often plays a crucial role in reducing family stress, improving the capacity of the family to care for their member with a disability, improving the quality of family life, and preventing long term out-of-

home placements (Botuck & Winsberg, 1991; Cavanagh & Ashman, 1985; Factor, Perry & Freeman, 1990; Grant & McGrath, 1990; Halpern, 1985; Joyce, Singer & Isralowitz, 1983; Lutzer & Brubaker, 1988; Marc & MacDonald, 1988; Rimmerman, 1989; Upshur, 1982). By providing relief from the care giving situation, respite care helps reduce fatigue, stress, and provide time for the family to take care of personal and family needs, such as recreation and personal growth activities, that would otherwise be difficult, if not impossible to do. Further, research has also found that the absence of community-based support services for families, such as respite care, is a significant contributor to a family's decision to seek an out-of-home placement for their member with a disability (Bromley & Blacher, 1989; Cole & Meyer, 1989; Sherman, 1988; Sherman & Cocozza, 1984).

However, even though public policy and service practices have led to an increased prevalence of family-based care, families have received only sporadic public support (Krauss, 1986). In many areas of the country, rather than providing the necessary resources to support families in their care giving roles, public resources have been used for services, such as foster care and community group homes, that serve as substitutes for family-based care.

Part of the problem lies in the fact that the deinstitutionalization movement has stressed the development of community based services to support individuals returning to the community. The emphasis on individualized services has meant that typically only the child or adult with disabilities is the client of services and professional support. When family members are involved in services, they, as care givers, have been viewed as resources to the person with disabilities, or as resources to the professionals by serving as members of the care giving team. In some cases, families have been viewed and treated as the source of the problem, one of the reasons why the pathology exists. Rarely have families been seen as needing supports and resources themselves (Moroney, 1979).

Recently, service professionals have begun to recognize the role of the family and the fundamental importance of healthy family functioning in providing the individual with a

disability the best opportunities for personal growth and independence. Further, by seeking information and control, and challenging authority in order to secure services to meet the needs of their family member with a disability, "parental entrepreneurs" (Darling, 1988) have advocated not only for the rights of their children but also for the rights of the family. In effect, support services for parents are increasingly being championed and implemented through legislative and policy changes. Yet, parents are frequently unaware of services that are potentially available to them (Ayer, 1984; Ineichen, 1986; Justice, O'Connor & Warren, 1971; Rubin & Quinn-Curran, 1984; Winton, 1986). Further, those services that are available have often been unable to adequately match family needs. Services have lacked individualization and flexibility, and have left parents powerless to modify the services that were offered (Agosta & Bradley, 1985; Herman, Thompson et al., 1992; Krauss, 1986).

Families caring for members with disabilities at home affirm that support services should be provided in a way that responds to the dynamic aspects of the family system (e.g., changes over the life span, multiple roles of family members), and responds to the family as a unit rather than just the individual with disabilities. For them, services need to be flexible and family-focused in order to match their family's needs throughout its life-cycle (Byrne & Cunningham, 1985; Gallagher & Gallagher, 1985; Herman, Hazel & Marcenko, 1989; Singer & Irvin, 1989; Turnbull, Summers & Brotherson, 1986). A growing number of family advocates have articulated a need for programs where the locus of control rests less with the state and professionals and more with the family; where "empowerment" (Katz, 1984; Rappaport, 1987) of families is a recognized and accepted goal (Dunst, Trivette & Deal, 1988; Herman, Hazel & Marcenko, 1989; Herman, Thompson et al., 1992). In order to empower families, service programs should encourage families' active participation in planning the service system, and render them control over designing and selecting the services they receive (Agosta, Jennings & Bradley, 1985; Herman, Thompson et al., 1992).

The Innovation: Family Support Services

Family support, a relatively new movement in the broader social services arena, is a model of service provision with the goal of providing community resources for parents in order to enhance their capacity in their child-rearing roles. By building strengths in families rather than 'curing deficiencies', family support creates settings in which parents are empowered to act on their own and their family's behalf (Kagan, Powell, Weissbourd & Zigler, 1987; Weiss, 1988, 1989; Weissbourd & Kagan, 1989; Zigler & Black, 1989).

Family support includes programs and policies which span the human services network. Relevant community-based programs include early intervention and parent education services in schools (Halpern, 1986; Hinckley & Ellis, 1985; Meisels, 1989; Roberts, Wasik, Casto & Ramey, 1991; Wiegerink & Comfort, 1987), home health aide services in public health agencies (Ireys & Eichler, 1988; Ireys et al., 1985; Soyka, 1976), and respite care services provided by mental health and developmental disability agencies (Cohen, 1982; Grant & McGrath, 1990; Salisbury & Intagliata, 1986; Starkey & Sarlie, 1989; Upshur, 1982). The diverse practices under the umbrella of "family support" are linked by common principles that stress the importance of prevention, an ecological approach to service delivery, and the universal value of social support (Weissbourd & Kagan, 1989).

The present study focused on family support initiatives within the developmental disabilities service system. Here, family support services foster family based care by providing necessary social, educational, physical, and financial supports to sustain family structure, maintain healthy family functioning, and reduce daily stress for families caring at home for their member(s) with a developmental disability (Agosta & Bradley, 1985; Krauss, 1986). The primary goal is to enhance the care giving capacity of families, thereby preventing or delaying out-of-home placement of the family member with a disability (Krauss, 1986).

In contrast to child and individual oriented service provision, family support services focus on the family as the unit to be supported and maintained. Consistent with family systems theory (Turnbull, Brotherson & Sommers, 1985), family support services should be constructed and implemented so as to allow for variation in family structure and functions over the life cycle of the family. A family-centered approach reflects the premise that the child is part of a family system, and that effective change for the child cannot be achieved without concern for the family (Cohen et al., 1989).

Further, based on the ecological premise that factors outside the family affect the family's capacity to nurture and rear its children (Bronfenbrenner, 1986), family support services recognize the interdependence of the family and its community (Agosta, 1989; Weiss, 1989). The ecological orientation requires that services be sensitive to the cultural and social traditions of the family and its community. It recognizes that building strengths with one family will have a "ripple effect that strengthens a community's collective capacity" (Weissbourd & Kagan, 1989; p. 22). Ecological based approaches to family support stress the principle that "natural" sources of support, including neighbors, extended family members, friends, and community associations, can be more effective and responsive to family needs than most government sponsored programs and professional services (Taylor, Knoll, Lehr & Walker, 1989). Thus, professional support services should, whenever possible, work to support existing social networks for families, strengthen natural resources, and help build connections within existing community resources (Center on Human Policy, 1987). Yet, in recognition of the isolation of many families, professional or agency operated support services need to be available when natural sources of support cannot meet the needs of families.

Barriers to Implementing Family Support. Although the goals and underlying service philosophy of family support are growing in acceptance, there is a wide diversity in the extent to which support services have been implemented (Knoll et al., 1990). Agosta and associates (Agosta, Bradley, Rugg, et al., 1985) identified three types of attitudinal

barriers which have constrained efforts to implement family support services. First, there has been a lack of professional consensus as to the role of the family in providing care and support. Some professionals discount the family's ability and capacity to make sound decisions and to care adequately for their family member; often leading to recommendations for out-of-home placements (Darling, 1983; Moroney, 1979). Other professionals do view the family as competent care givers and see the positive benefits the family can provide. They relate to family members as teachers, trainers and case managers for the individual with disabilities, but fail to see family members as needing supports themselves. This often results in further expectations placed on the family by professionals to fulfill required roles, with little increase in expectations placed on the service system and professionals to support the family's efforts (Rubin & Quinn-Curran, 1983).

Second, attitudes favoring family-based care assume a 'traditional' family system; a family member, usually the mother, will remain at home to care for the person with a disability. This assumption is inconsistent with current social and economic trends (Agosta, Bradley, Rugg, et al., 1985). With high divorce rates and births out of wedlock, the fastest growing family form is the single-parent family headed by a woman (Schroeder, 1989). Thus, family-based care is difficult for many 'families' to carry-out without additional supports. Public support services have not kept pace with these changes and families that do not fit the traditional mold have been penalized (Schroeder, 1989).

Third, Agosta and associates (Agosta, Bradley, Rugg, et al., 1985) point out that society has yet to reach a consensus on the public's role in private family affairs. Much public opinion holds that the State should assume responsibility to provide the necessary resources for the care of the individual only after the family is no longer able to care, or decides to relinquish their responsibilities by placing their family member in an institution or other out-of-home care situation. These attitudes are reflected in fiscal patterns which focus most of the public service dollars on out-of-home care.

Implementation of comprehensive support services for families would require a significant re-allocation of existing funds. However, because many policy makers believe that current fiscal resources are scarce, and because there are significant pressures to maintain current allocation patterns, they are reluctant to support further implementation of family support programs. In contrast, those supporting family-based care argue that the family should be provided with adequate resources to live a life that is as close to normal as possible. Support services that help the family to care for their member at home are more cost efficient in the long run than out-of-home placements (Agosta, Bradley, Rugg et al., 1985).

Evidence of the Implementation of Family Support Services

It is clear that, due to various ideological and attitudinal barriers surrounding the interplay of family versus public support, the establishment of an effective state wide family support program can be a complex political and administrative task. Despite these barriers, available evidence indicates that public officials are increasingly meeting the challenge and are slowly beginning to clarify and implement family support initiatives. In 1984, 22 states had developed family support services (Agosta, Jennings & Bradley, 1985). A more recent national evaluation of state and local efforts indicated that 41 states had developed programs with a specific focus on supporting families who are caring for a child with a developmental disability (Knoll et al., 1990). Yet, there was a wide diversity in the extent to which family support was firmly established in each state. Only twenty states had legislation which mandated some type of family support initiative, and at the other extreme, 10 other states were only running pilot projects.

There also existed a wide diversity in methods and models of providing family support. The number of different types of support initiatives available in any one state ranged from 0 to 27. These initiatives were broadly categorized into three activities: services, service coordination, and financial assistance. Table 1 shows the different types of initiatives, within each category, that were provided by family support programs. Within the services

category were initiatives which were provided to assist and enable the family to care for their member with a disability such as respite care, behavioral management training, attendant care services, and transportation. Other services were provided to help support the family in dealing with stresses, such as family counseling, support groups, and stress management training; while others were focused on community integration and empowerment such as parent to parent networking, and advocacy. Services that focused on enabling the individual with disabilities to access his/her environment and become more integrated into the community, such as adaptive equipment, home renovations, special therapies, and recreation programs, were also seen as helpful for the family.

The second category of initiatives, family-based case management, aims to empower the family by connecting them with a person in the system who can help them advocate and access the services in their community (Dunst & Trivette, 1981). Working in partnership with the family, a family advocate or case worker can also help families coordinate the multiple services, entitlements, and insurance programs with which they are involved.

The third form of family support is financial assistance programs. These programs provide funds to the family so that the family can purchase needed services and supports available from both private and public service programs. Financial assistance programs vary in the amount of cash provided, eligibility standards, means of disbursement, and the degree of control and flexibility a family has in determining how the funds are used (Agosta, 1989). The most empowering programs are those, such as the subsidy program in Michigan (Arneaud & Herman, 1989; Herman, 1986, 1991; Meyers & Marcenko, 1989; Parrot & Herman, 1987, 1988), which render to the family total control over the spending decisions of the financial assistance provided.

Knoll and associates (1990) noted other differences in the way family support had been implemented. Not only did the number of services vary, but the combinations of services that had been implemented varied. Comparing across states, four general combinations of family support initiatives were found: respite care only, other support services, financial

Table 1: Family Support Activities Across the Nation.

SERVICES:

Respite and Child Care
- Respite and sitter services
- Day care services
- After school care services

Environmental Adaptations
- Adaptive equipment
- Home modifications
- Transportation vehicle modifications

Counseling and Peer Support
- Family counseling
- Family support groups
- Peer support groups
- Parent to parent networking

Parent Education and Training
- Behavioral management training
- Stress management training
- Parental skills training

Traditional Developmental Disability Services
- Speech, physical and occupational therapies
- Individual counseling
- Medical and dental care
- Skills training
- Evaluation and Assessment

In-home Assistance
- Homemaker and chore services
- Attendant care services
- Home health care services

Recreation
- Summer camp programs
- Community recreational programs
- Companion programs

Extra-ordinary and Ordinary Needs
- Transportation
- Dietary and clothing assistance
- Health and dental insurance
- Rent and utility assistance

Systemic Assistance
- Information and referral
- Advocacy
- Legal assistance

CASE MANAGEMENT and SERVICES COORDINATION

FINANCIAL ASSISTANCE
- Discretionary cash subsidy
- Allowances and lines of credit
- Reimbursements and vouchers

Adapted from Knoll et al. (1990)

assistance only, and a combination of financial assistance and support services. Other differences in implementation found across the Nation included variations in: structural and administrative patterns, such as centralization of services and state versus local control over resources; eligibility for services, based on the age of the individual with disabilities and the severity of their disability; and the extent to which family support was consistently and equitably available throughout the state.

In general, Knoll and his associates (1990) concluded that the family support efforts they discovered were "few and small". The majority of states were only starting to explore family support and, as such, had not yet made a full commitment to supporting families. Because, family support in most states had been sold to policy makers under the rubric of 'prevention' and cost effectiveness, the assistance that was provided was usually enough to avoid costly out-of-home placements for some families, but not enough to establish a family- and community-centered service system state-wide. The actual fiscal commitments to family support were minute portions of the overall budgets allocated for services for persons with developmental disabilities. The majority of funds were still largely absorbed by substitute care programs. The basic values of family support, that of developmental disability services as community-based and family centered, were only beginning to be recognized in a few states.

Focus of the Study: Implementation of Family Support in Michigan

Michigan has consistently been identified as a national leader in family support services (Agosta, 1989; Center on Human Policy, 1987; Knoll et al., 1990; Krauss, 1986; Slater & Wikler, 1986; Taylor et al., 1989). As early as 1978, Michigan was implementing family support services. Michigan's family support efforts are the outcome of several forces including effective parental advocacy, bureaucratic innovativeness, and legislative action. First, in response to parental advocacy, funds were appropriated from the legislature through the Department of Mental Health for a pilot project in Lansing. The family support effort was subsequently expanded in the next fiscal year to include five additional

demonstration sites funded by the Services Research Division of the Department of Mental Health (Herman, 1983; Mowbray & Herman, 1991). Three of these demonstration sites were able to successfully implement family support services and were continued through 1982 with support funds from Michigan's federally mandated and funded Governor's Council on Developmental Disabilities (DD Council). An evaluation (Herman, 1983) indicated that throughout the implementation of the demonstration projects, none of the families who participated placed their children in settings outside of their home (e.g., institution, foster care, or group home). Further, families viewed the services as a positive sustaining force in their lives.

The positive results of the demonstration sites helped spur efforts to expand family support across the state. In 1983, through advocacy of parent groups and key policy makers in both the legislature and state bureaucracy, the Department of Mental Health received funding authorization from the legislature to expand family support services. The three successful demonstration sites along with the initial pilot site were recommended for operational status. Further, the remainder of the State's 55 county-based community mental health boards were encouraged to adopt at least two components of family support as part of their ongoing services: client services management and respite care. Between 1983 and 1986, the State provided $4.65 million to the boards to establish or expand family support services (Herman & Hazel, 1991).

In response to the proposed expansion, the DD Council funded a project to disseminate information regarding family support services in order to encourage the adoption and expansion of family support services at the boards. The project was implemented by the Michigan Association of Community Mental Health Boards. The Association provided descriptive pamphlets and other forms of assistance to the boards in order to aid them in formulating expansion requests, and planning and implementing family support services. This project also organized monthly meetings of board staff who were assigned the task of implementing and providing family support services. These meetings provided a forum for

information exchange and support and the beginnings of a network of informal technical assistance that could be drawn upon when implementation difficulties arose. This group was later formalized into a state-wide "Family Support Coordinator's Council" and has been instrumental in advocating for and developing new family support initiatives (e.g. Medicaid policy changes).

Further impetus for family support services came from legislative authorization of the Family Support Subsidy Program. Established as part of the Michigan Mental Health code (P.A. 249, 1983), families with children under age 18 who are severely mentally impaired, severely multiply impaired or autistic impaired, and who have a yearly taxable income less than $60,000, are eligible to receive a uniform monthly stipend to help them care for their child (Michigan Department of Mental Health [MDMH], 1986). The subsidy program, administered by the Department of Mental Health, began operation in July 1984 and by August 1988 had over 3300 families enrolled (Arneaud & Herman, 1989). Each family received $256.74 per month per child with a disability.

In June 1984, in recognition of the growing demand for and implementation of family support services across the state, the Department of Mental Health amended its administrative guidelines to establish policy and standards for the provision of family support services (MDMH, 1984). Service and administrative components of family support were defined through the combined efforts of the DD Council and the Department of Mental Health. Some of the components are similar to national trends (see Table 1) while others are unique. The components include: consumer input through formal parent advisory committees, case management and advocacy, respite and sitter services (including family friend respite services), information and referral services, parent training and education, in- and out-of-home support services (e.g., chore, medical, nursing, special therapies), family and sibling counseling services, family peer support groups, accommodative home improvements and adaptive equipment, crisis intervention placement,

individualized family service plans, and a cash subsidy program (Michigan Developmental Disabilities Council [MDDC], 1988; MDMH, 1988).

Family support services have continued to evolve in Michigan. A comparison of state-wide evaluations of family support services pre- (Herman, 1984) and post-dissemination (Herman & Hazel, 1987) indicated an overall increase in service delivery across the state. By 1985, all 55 boards had at least some family support services available, and over 90% of the boards provided case management and respite care services (Herman & Hazel, 1987, 1991). However, despite this growth, the mainstay of most programs was a group of service components characteristic of traditional outpatient services (e.g., case management, assessments, counseling, and psychiatric consultations) developed to support deinstitutionalization and community placement, bolstered by some respite care (Herman & Hazel, 1987). Few agencies had implemented programs with distinct family orientations. Support services such as in-home nursing, parent or family support groups, parent training and education, and home renovations were not widely available. It was concluded that although resources remained a significant factor in implementing family support services, this factor did not completely explain the continuing lack of family oriented programs. Resource intensive services, such as case management, respite care, and assessments were widely available. Yet, less intensive components such as support groups, parent advisory committees, and parent training classes were not widely available. The authors argued that what was needed to increase the availability of family support was a shift in the philosophy of service providers to view services for families as supportive, rather than as treatment (Herman & Hazel, 1987).

Although no new mental health funds were specifically targeted for family support services since the initial expansion funding in 1984-1985, several factors spurred the continued adoption and implementation of family support across the state. These factors included changes in Department of Mental Health policy which reflected the growing demand for family support, the emergence of a state-wide Family Support Coordinator's

Council, and advocacy, evaluation, and demonstration project activities of the DD Council. Results of a recent five year follow-up evaluation of the availability and accessibility of family support services (Table 2) indicated some expansion in and refocusing of service components along with the development of programmatic administrative structures (Herman, Thompson, et al., 1992). As of 1990, all but one board reported having respite care services available to families (Herman, Hazel, Thompson & Linklater, 1992a), and 38 boards (69%) had implemented an identifiable family support program which included a wide range of service components under the auspices of a family oriented program administrative unit (Herman, Thompson, et al., 1992). Further, 22 boards (40%) had added a parent advisory function to the agency's decision making process regarding family support services (Herman, Hazel, Thompson & Linklater, 1992b).

Nevertheless, despite continued growth, it is clear from this information that family support is still not a fully implemented service philosophy. Similar to variations across the nation in family support service implementation, variations exist in local responses to policy and advocacy incentives to implement family support in Michigan. Although family support philosophy seems to have increased in acceptance with the implementation of family oriented program structures and more parent advisory committees, the overall lack of family oriented, low resource intensive service components remains.

Need and Rationale for the Study

What factors account for the variability in the implementation of family support services? Evaluation research regarding state and national implementation efforts points to the role that resources, incentives, and various organizational characteristics play in local configurations of family support services. Ireys and associates (1985), studying the variation in states' implementation of 'Crippled Children's Programs', found that the percentage of clients served was positively correlated to per capita expenditures ($r = .40$, $p < .02$). Relatively wealthier programs served more children. Further, regression analyses

Table 2: Family Support Services in Michigan.

Service Component	# Agencies Providing (*N*=55)
Family case management	45
Family friend respite care	47
In-home respite (not family friend)	30
Out-of-home respite (not family friend)	41
In-home parent behavioral management training	26
Parent education classes	20
Parent-to-parent networking	17
Newsletter	16
Parent or family support group	20
Family counseling	36
In-home nursing	16
In-home special therapies	9
In-home behavioral management trainer	22
Adaptive equipment	16
Home renovations	9
Recreation or campership program	21
After school or day care program	4
Administrative Structure	
Program Structure	38
Parent Advisory Committee	22
Line Budget for Respite Care	31

From Herman, Thompson, et al. (1992)

suggested that programs located in wealthier states were likely to provide more coverages to a wider range of disabling conditions (coefficients not reported).

Castellani and associates (1986), studying the availability and accessibility of family support services in New York State, found that the greatest availability of family support services was reported by government agencies. Similar to Ireys and associates, larger agencies (measured by budget size and number of clients) provided more services, although not more types of services. Further, overall availability was related to population density and county wealth; wealthy, urban counties reported more family support service programs available. Further, a wider range of support services were available in the less wealthy and rural counties. However, these results were based on percentage comparisons, no probability statistical tests were used to evaluate the observed differences.

Herman and Hazel (1991) evaluated the change in availability of family support services following a dissemination effort accompanied by a large influx of incentive funding to Michigan's public mental health system. They discovered a general increase in family support services across the state. In regard to the effect of funding on service availability, agencies that had received lower levels of funding reported a significant reduction in the variety of services provided. Agencies that received average to large amounts of funding had either increased the number of different services or had remained stable. However, no statistically significant correlation was found between funding and change in services implementation.

What is clear from a review of the scant research evidence regarding family support services is that variations in implementation have been most often related to structural aspects of the organization and community. However, methodological problems exist in that few researchers reported correlation or regression coefficients or used probability testing to show that observed differences were statistically significant. Research has also neglected an examination of the characteristics of the individuals involved in implementing the services, such as their attitudes and beliefs. Research regarding the implementation of

family support services needs to take into account not only the structural and administrative variables related to program characteristics, but also the role that the implementers play in the design and delivery of service programs. In particular, research should focus on the question of what relationships exist between implementers' beliefs and attitudes and the character of family support service programs they implement.

Michigan has been the focus of a rather intense longitudinal evaluation effort focused on the implementation of family support services (Herman, 1983, 1984; Herman & Hazel, 1987, 1991; Herman, Hazel & Marcenko, 1989; Herman, Marcenko & Hazel, 1991; Herman, Thompson, et al., 1992). Thus, focusing on Michigan's family support service system provided an opportunity to integrate historical information with current evaluative data, thus providing ample contextual information for understanding the relative importance of individual and organizational characteristics for program implementation.

Research Hypotheses

The principle hypothesis explored by this research is that organizational performance is determined by structural characteristics of the organization and its environment, and characteristics of the individuals that make up the organization. In regard to family support, variations in local responses to policy initiatives have been primarily related to various structural characteristics of agencies and the context in which they operate. This research proposed a new line of investigation which included both structural characteristics of the organization and its context, along with attitudes and beliefs of service agency personnel.

The strategy used in this research was to examine a number of bivariate relationships that have been found in previous research to be potential predictors of innovation implementation, and then to re-examine these relationships within a multivariate framework. Few phenomena are products of a single cause, including implementation. Evaluating the effect of one variable without consideration for the effects other variables

may have on implementation, such as would be the case using bivariate analyses, creates bias in the research results. Multivariate analysis, on the other hand, allows for the effect of a particular variable to be made more certain, for the possibility of distorting influences from the other variables can be accounted for (Lewis-Beck, 1980).

The following discussion presents definitions of the criterion and predictor variables and the specific hypotheses explored in this research. Also presented is a review of relevant literature regarding the hypotheses. The chapter ends with the explication and discussion of a proposed exploratory path model based on Lewin's (1951) field theory and Ajzen and Fishbein's (1980) theory of reasoned action.

The Criterion: Innovation Configurations

Family support is a relatively new and innovative service philosophy within the human services arena, thus the introduction of family support to the developmental disabilities service system has necessitated a significant redirection in service philosophy, types of services offered, and methods for providing those services. The observed variety of approaches to family support are similar to the variety of program adaptations that have been found by researchers evaluating the adoption and implementation of innovations in organizations (Blakely et al., 1987; Glaser et al., 1983; Rice & Rogers, 1980; Rogers, 1983; Roitman, 1984; Scheirer, 1981; Van de Ven & Rogers, 1988). Evaluators have discovered that during the course of implementation, a multitude of variables interact to change not only the organization and its people, but also the innovative policy or program that is being implemented. The term "innovation configurations" (Hall & Loucks, 1978) was introduced to describe the variety of ways innovations are reinvented or adapted to fit the needs of the implementing organization. According to Hall and Loucks (1978), "innovation configurations are the operational patterns of the innovation that result from selection and use of different innovation component variations" (p. 9).

Research has shown that there is a tendency for adopters of an innovation to only implement selected aspects of the innovation rather than the entire innovation (Hall &

Loucks, 1978; Rogers, 1983). Rogers (1983) suggested that characteristics of the social innovation, such as whether it involves a single entity or a cluster of technologies, can influence the extent to which it may be adapted. A narrowly defined and well integrated innovation, in which all components are highly interdependent, and which has achieved a stable and commonly shared conceptualization, is least likely to be adapted (Rice & Rogers, 1980). In contrast, an innovation cluster which is less structured and defined, i.e. "loosely bundled", allows for more flexibility in designing locally acceptable versions of the innovation. Adopters can mix and match components of the innovation cluster to match their needs and interests. Research has shown that modifications which fit the innovation into preexisting patterns of organizational behavior, can make it seem to be a less radical change than it potentially is, and therefore more acceptable to the local system (Rogers, 1983).

Regarding family support, a number of services have been identified as components of the innovation (see Table 1). These components are most characteristic of a 'loosely bundled' technology cluster, and therefore family support in practice is highly adaptable to local conditions. In Michigan, Herman (1983) found that the initial family support demonstration projects represented varied configurations of services. Even though case management and respite care had been implemented across all projects, the evaluation identified four distinct models of service delivery that were based primarily on preexisting organizational and community service practices (Mowbray & Herman, 1991).

Information gathered by the five year follow-up study indicated that the number of service components (identified in Table 2) that were implemented at any one board ranged from 0 to 15 (Herman, Thompson et al., 1992). Administrative practices also varied. As was mentioned previously, 69% of the boards had implemented a family support program structure. Yin (1981) used the term 'routinization' to describe how innovations become part of an organization's standard practice, and thus are less likely to suffer cuts during times of financial exigency. Yin suggested that events such as the establishment of

appropriate organizational status for the program, hiring and training staff for the program, and identification of local funding, among others, were needed to sustain any organizational practice over time. As a relatively new service philosophy within the mental health system, the extent to which family support has become routinized through various administrative practices, such as the identification of a program structure and line item budget for services, may be indicative of continued utilization.

For this research, the resultant character of family support, i.e., the criterion, was operationalized by two specific configurations. The first criterion described the range of different services provided. The other described the degree of administrative formalization of the services (similar to routinization), such as whether or not the agency had implemented a program structure from which family support services were administered, whether there was a line-item budget for respite care services, and whether the agency had implemented a parent advisory council for family support services.

Organization and Context Predictors of Innovation Configurations

A variety of factors have been proposed and therefore are potentially applicable to the prediction of innovation configurations. In general, the literature suggests that organizational adoption and implementation of innovations is influenced by characteristics of the organization, characteristics of the context in which the organization operates, and characteristics of individual people in the organization (Kimberly & Evanisko, 1981).

Organization size. Various authors studying the diffusion of social and technological innovations have argued that characteristics of an organization's structure are related to innovation and program change. Innovation diffusion research has related an organization's size, centralization, complexity, and formalization to its willingness to innovate (Davis, 1982; Hage & Dewar, 1973; Havelock, 1971; Glaser et al., 1983; Moch & Morse, 1977; Rogers, 1983; Scheirer, 1981; Zaltman, Duncan & Holbek, 1973). The size of the organization has most consistently been used a predictor of an organization's willingness to innovate or adopt new programs (Glaser et al., 1983; Kimberly & Evanisko,

1981; Rogers, 1983; Moch & Morse, 1977; Nord & Tucker, 1987). In general, larger organizations often have access to more resources and the capacity to shift internal resources in order to support new programmatic initiatives. The amount of organizational 'slack' in resources has been found to be positively related to innovation adoption (Rogers, 1983). Since large organizations tend to have more slack, they are in a better position to be more innovative than smaller ones.

The size of an agency's budget or its expenditures have often been used in research to operationalize the concept of organizational size. As discussed previously, research regarding family support services has found that expenditures were related to service implementation (Castellani et al., 1986; Ireys et al., 1985). However, the relationship between size (as measured by budget size) and the breadth of services provided is not clear. Ireys and associates (1985) found that larger agencies (based on program per capita expenditures) provided a broader range of services (r = .19, n.s.), however, the relationship was not statistically significant. In contrast, Castellani and associates (1986) found that size was not related to the number of services provided. The number of services provided was more related to population density and service area wealth. Once again, this finding was based on percentage comparisons, the differences were not tested for statistical significance.

In Michigan, funding patterns for mental health services vary across the organizations responsible for implementing family support services. Some agencies have larger budgets than others, allowing for larger staff sizes and more resources to support service provision and administration. In this research, the agency budget was used as a measure of the overall size of the agency. It was hypothesized that agencies with larger budgets would have implemented more services and more formal administrative structures.

Context characteristics. The characteristics of the community served by an organization can affect its ability to implement innovative policies and procedures (Glaser et al., 1983; Havelock, 1971). The community can provide pressures and demands that

either encourage change in the organization or constrain innovative practices. However, the research to this point is not clear as to the relationship between context characteristics and implementation configurations. The importance of the context in which an organization operates for its innovative practices has been acknowledged conceptually, but rarely examined empirically.

Baldridge and Burnham (1975) examined the relationship between environmental factors, such as population density (r = .30), racial mix (r = .25), urbanization (r = .37), wealth (r = .06), and government expenditures (r = -.26), and innovative behavior of educational organizations (statistical significance estimates not reported). They found that organizations with heterogeneous environments (i.e., urbanized, racially mixed, dense population) were more likely to adopt innovations than organizations with relatively stable, homogeneous environments (r = .27). In comparisons of organization size/complexity (R = .49), and environmental change (i.e., migration, growth, change in wealth and racial mix) (R = .57), environmental variables explained 31% of the variance in innovativeness (R = .56). However, when examined simultaneously with organizational variables (i.e., size and complexity), environmental variables (R^2 change = .08) explained only 8% more of the variance already explained by the organizational variables (R^2 change = .24).

Kimberly and Evanisko (1981) studied the influence of individual, organization, and context factors on hospital adoption of technological and administrative innovations. They found that context variables, such as competition and population size, were predictive of technological innovations (R = .55), but not of administrative innovations (R = .32). When individual, context and organizational variables were considered simultaneously, context variables were not predictive of innovativeness.

Context characteristics have also been related to the implementation of family support services (Castellani et al., 1986; Ireys et al., 1985). Agencies in wealthier and more dense service areas provided more services, while those in less dense and wealthy areas provided

a broader range of services (Castellani et al., 1986). Once again, comparisons were not tested for statistical significance.

In Michigan, agency service areas vary in regards to population size and density, economic vitality, and demand for family support services. These context characteristics can potentially create a demand for and support the implementation of family support services. Since the research literature is unclear as to the relative importance of environmental factors in the determination of innovation configurations, demand for services, service area population size and density, and service area wealth were evaluated in order to determine the relative explanatory power of these context characteristics to family support configurations. It was hypothesized that agencies with larger and more dense populations, higher demand for services, and wealthier service areas would have implemented more services and more formal administrative structures.

Individual Level Predictors of Innovation Configurations

Organizational decision making is in large part a function of individual decision making, and thus, it is useful to look at how individuals within an organization evaluate the innovation (Zaltman et al., 1973). Individuals responsible for implementing change act not only from internal and external organizational incentives but also from professional and personal motivation (McLaughlin, 1987). Several researchers have argued that the ideology, interests, and agendas of local actors have a major impact on implementation (Berman & McLaughlin, 1978; Browning et al., 1981; McLaughlin, 1987; Zaltman et al., 1973). Innovations are more acceptable, and thus, more likely to be implemented if they appear to be compatible with the user's previously established values, norms, procedures and resources (Glaser et al., 1983).

However, innovative practices are frequently in conflict with existing attitudes, customs and beliefs of agency personnel. This situation often discourages adoption and implementation of innovative programs. For an innovation to be accepted and thus implemented, it must be assimilated within the professional ideology and practice of the

adopting organization's personnel. Innovations which run counter to the ideological orientation of agency personnel require a change in their attitudes and beliefs before the innovation can be fully implemented. Therefore, characteristics of people, their social roles and attitudes toward the innovation, may strongly affect the implementation process and resultant innovation configurations.

Specific to family support, Knoll and colleagues (1990) and Agosta and colleagues (Agosta, Bradley, Rugg, et al., 1985) argued that diversity in family support initiatives may correspond to the extent to which service providers subscribe to values associated with family-centered and family empowerment oriented service provision. Taylor and his associates (1989) argued that the degree to which service providers are committed to the core values of a policy initiative largely determines the quality of the services available to families. Yet, none of the empirical studies have systematically examined the beliefs and attitudes of the individuals responsible for implementing family support programs at the local level.

Stakeholders. The present study tested the general hypothesis that the character of family support services at the agency level is influenced by the attitudes and beliefs of the stakeholders in the implementation process at the local level. Stakeholders have been defined as those "whose participation and cooperation is needed to operationalize a policy" (Hasenfeld and Brock, 1991, p. 468). The stakeholders in the implementation of family support services are those who are in a direct decision making line regarding those services, from the top of the organizational leadership to the 'front line' workers. These stakeholders include individuals directly responsible for the operation of family support services, such as the family support and respite care coordinators, and those people involved in the management of developmental disabilities services in general. Also included in the stakeholder category are those people responsible for the decision making of the organization as a whole, such as the agency directors and chairperson of the board.

Attitudes toward the innovation. An individual's attitudes regarding a change program influence that individual's willingness to carry out the necessary implementation tasks (Scheirer, 1981). How individuals within the organization interpret their knowledge and understanding of family support can greatly influence implementation. Backer and associates (1986) noted that in mental health organizations, emotional reactions of participants to a change program were critical to successful adoption and implementation. Other researchers have noted that attitudinal resistance to the implementation of an innovation may be so great that it is never fully or properly implemented (Fairweather et al., 1974; Glaser et al., 1983; Rogers, 1983).

Zaltman and associates (1973) argued that attitudes affect individuals' exposure to new information, their perceptions of the innovation and change, and their actions toward the change. Attitudes provide a cognitive framework from which a person interprets new information, screens out unwanted information, and evaluates potential consequences of the change, thereby helping the individual to determine which actions to take. Consequently, attitudes held by organizational personnel can either build and maintain support for the status quo and thus lead to resistance to change, or can encourage innovation and change.

Research and theory of Ajzen and Fishbein (1980) suggests that intentions to perform a particular behavior (i.e., to implement family support services) are a function of two constructs: attitudes toward the behavior and the subjective norm for that event. Their theory of 'reasoned action' hypothesizes that a person forms an attitude toward the behavior (i.e., the implementation of family support services) by subjectively evaluating the consequences that are likely to occur if the behavior is carried out. If those consequences are determined to be salient and positive, the likelihood of the person carrying out the behavior increases. In general, their theory suggests that a person who believes that implementing family support services will lead to mostly positive outcomes will hold a favorable attitude toward family support, while a person who believes that implementation

will lead to mostly negative outcomes will hold unfavorable attitudes. As a result, attitudes held by stakeholders determine their intentions, and thereby their behaviors, to implement family support services.

The second determinant of the behavioral intention is the person's evaluations of the subjective norm for the behavior; in this case, their beliefs regarding the social pressures to implement or not implement family support services. I will discuss this factor, along with the role of behavioral intentions, in the next section regarding beliefs about driving and inhibiting forces.

Other research and theory has stressed the fact that people have a limited capacity for absorbing change and therefore may resist change that seems to occur too fast (Legge, 1984). The degree to which agencies have implemented an innovative program at any particular point in time is dependent on the amount of time needed for that organization and its personnel to become comfortable with the necessary changes. Some organizations and individuals are more readily accepting of change than others and, therefore, are more likely to implement the changes at a faster pace. Thus, the resultant variability in family support configurations, especially agencies which have implemented very few services, can also be seen as a resistance response to change.

Sabatier and Mazmanian (1981) noted "the greater the amount of behavioral change, the more problematic successful implementation" (p. 9). Innovative policies which require a rapid change in basic operations will meet more resistance than ones which can be gradually implemented over time. In agreement, Rogers (1983) noted that innovations which can be viewed as "demonstrations" or "trials" are more likely to be implemented than innovations which are seen as permanent, unmodifiable changes. Innovations which can be implemented in small doses, thus allowing for new skills and procedures to be learned and implemented gradually, are less threatening.

Thus, implementation of a new policy or service delivery process, such as family support, can be marked by the emergence of reactions to the change in the form of

resistance. The extent of the resistance will be influenced by the amount of perceived change required of the organization and its personnel and the degree to which personnel are accepting of the changes (Legge, 1984). Attitudes of agency personnel toward changes required to implement family support services may, therefore, have an impact on the resultant configurations of services implemented at the agency. For example, the implementation of a parent advisory council requires changes in attitudes regarding the role of parents in the service delivery process and also changes in behavior patterns when interacting with parents. Parents can no longer be seen as passive recipients of services or treated with indifference, but must be accepted as active partners in service delivery and incorporated into the decision making process. Also, the creation of a program structure may require a reorganization of the agency which could potentially shift the power structure away from more traditional developmental disability services. Consequently, openness to change by those involved in implementing new policies is critical to the success of family support.

Little research, if any, has directly examined the relationship between attitudes and the resultant implementation of innovative programs. Theories and research regarding attitudes and reactions to change suggest that attitudes regarding the innovation and associated changes may play an important part in the determination of implementation practices. Therefore, attitudes of stakeholders regarding family support and associated changes, such as parent involvement in decision making, were evaluated in order to determine their relative importance to the explanation of family support services configurations. It was hypothesized that agencies in which personnel expressed favorable attitudes toward family support philosophy (e.g. family centered and driven services) and the implementation of family support at their agency would have implemented more family support services and more formal administrative structures.

Beliefs regarding driving and inhibiting forces. Structural characteristics of the organization and its environment are not static forces. Within a dynamic ecological context these forces can directly inhibit or enhance the implementation of new programs by providing the necessary resources and push to support the implementation of innovative programs, or not. However, measures of organization and context elements that hinder or constrain innovation implementation are not always readily available from secondary data sources or easily obtained by direct measurement. Even so, as Kurt Lewin's field theory suggests (Lewin, 1951), behavior is a function, not of the objective environment, but the subjective. A person's perception of their environment primarily directs their behavior. Therefore, in order to understand how forces in the environment impact family support services implementation behavior, it is important to understand the perceptions or beliefs agency personnel hold in regard to those forces.

According to Lewin's field theory, agency structure and context forces not only have direct impacts on implementation but also have indirect effects based on what agency personnel believe to be the nature of the push and support for the implementation of the innovative program. If personnel do not perceive a need for or believe that there are resources to support the new program, it is unlikely that the organization will carry out the necessary tasks to implement the program. For example, resources may be available to develop the new program, but unless people in the organization believe a need exists they may not search for and access those resources. In contrast, if people are aware of resources and recognize that a need exists, they are more likely to implement the new program.

Therefore, a potentially valuable means of measuring the effects of structural and context forces is to ask people in the organization what they perceive to be the forces which have either inhibited or encouraged the implementation of the innovative program in question. In the five year follow-up study of family support services in Michigan, service providers and administrators identified a number of factors which they believed to inhibit or

encourage the growth of family support services (Herman, Thompson et al., 1992). Identified factors included organization structure and context issues, such as funding, demand, community resources, need, and agency resources, and also characteristics of agency personnel, such as their attitudes and perceived support from administration. However, the open-ended question format did not allow for an examination of the extent to which particular factors explained the variability in family support configurations. Comparability across the agencies of the impact of any particular factor was not possible.

As noted earlier, Ajzen and Fishbein's (1980) theory of 'reasoned action' suggests that a person's intentions to implement family support services are in part a function of the person's perception of the social pressures (i.e., the subjective norm) to implement or not implement family support services. During the implementation process, individuals seek reinforcement for their actions by observing the attitudes and behaviors of their clients, colleagues and supervisors (Rogers, 1983; Zaltman et al., 1973). This process of legitimation helps the individual to determine the appropriateness of their actions, lending support and motivation for further actions. For example, a person who perceives that clients, colleagues and supervisors think family support services should be implemented will feel social pressure to do so. Conversely, a person who perceives that clients, colleagues and supervisors think family support services should not be implemented will have a subjective norm that puts pressure on him/her to avoid implementing family support services. Thus, a person's beliefs regarding the degree of support held by other agency personnel for the implementation of an innovative program determine, in part, his/her response to the situation. Without a belief that their actions will be supported, agency personnel may waver and thus not implement family support to its fullest capacity.

Backer and colleagues (1986), in reviewing successful innovation dissemination efforts, noted that organizational support for the innovation was critical for successful adoption and implementation. During the follow-up evaluation of family support services in Michigan, family support coordinators identified support from agency administration as

a key factor that either hindered or enhanced the implementation of family support services (Herman, Thompson et al., 1992). Although beliefs of agency personnel may be predictive of the outcomes of the implementation process, very few, if any, researchers have systematically evaluated this possibility. Therefore, beliefs regarding the forces that have inhibited or enhanced agency implementation of family support services, such as agency capacity, state funding, family and community support, and support from colleagues and supervisors, were explored in order to determine the relative importance of these variables to the prediction of family support configurations. In general, it was hypothesized that agencies in which stakeholders' believed there to be sufficient capacity, high levels of family and community support, and support from staff and administration would have implemented more family support services and more formal administrative structures.

Further, as suggested by reasoned action theory, it was hypothesized that behavioral intentions would be predictive of family support configurations, and would moderate the relationship between attitudes/beliefs and the criteria. Thus, stakeholders' perceptions of their agency's willingness to hire and train staff for family support and their preferences for expansion and improvement of family support were measured. It was hypothesized that agencies in which personnel favored the expansion and improvement of family support, and in which staff were hired and trained for family support would have implemented more services and more formal administrative structures. The effectiveness of behavioral intentions as a mediator between the relationship of attitudes and beliefs with the criteria was explored in the path model, which I present in the last section of this chapter.

Organizational status and decision making involvement as moderator. One of the most frequently cited generalizations regarding resistance to innovation is that it occurs when those affected by a change perceive it as threatening (Glaser et al., 1983). Legge (1984) suggested, based on an exchange-theory approach, that individuals calculate the balance of costs and benefits to themselves, and to the organization, and decide whether

to accept or resist the proposed change. Individuals who view the innovation as providing more benefits to themselves and the organization will be more supportive of the implementation process; while those who view the innovation as less than beneficial may choose to resist, either passively or actively, efforts to implement the innovation. People who have benefited the most from an existing order are unlikely to welcome a major change. Fear of loss of status, prestige and power is often cited as a major reason for resistance to change (Glaser et al., 1983).

Power holders in the organization may resist required changes of an innovative policy because of their "vested interest" in the existing order. Innovations which are perceived to devalue a person's acquired knowledge and skills are threatening and therefore, less likely to be fully implemented (Glaser et al., 1983). Fairweather and his colleagues (1974), in disseminating the Lodge program for people with mental illness, noted that innovations which involved social status and role changes were less likely to be adopted or fully implemented. This "top-down" (Sabatier, 1987b) perspective suggests that innovations which threaten the established power hierarchy are not likely to be implemented without the power hierarchy's acceptance and cooperation. Hasenfeld and Brock (1991) noted that when the group that controls the key resources in the organization is in conflict with the proposed changes, the agency is more likely to undertake symbolic rather than substantive implementation. The organization may comply with the formal requirements of the policy but with minimal commitment of organizational resources. Backer and associates (1986) in their study of the dissemination and adoption of three innovative psychosocial interventions, concurred that organizational support for the innovation, particularly from top management, was critical for successful implementation.

However, from the "bottom-up" perspective, social innovation diffusion researchers (Fairweather et al., 1974; Berman & McLaughlin, 1977, 1978) and program implementation analysts (Scheirer, 1981) have noted that participation of direct service providers in the decision making surrounding the implementation of innovative programs is

essential to effective implementation. The fundamental flaw in top-down models of policy implementation is that they assume that the framers of the policy decision are the key actors and that others are basically impediments (Sabatier, 1987b). Initiatives of local implementing officials and other community resources are neglected in policy decisions, often resulting in less than effective program implementation. Hjern and colleagues (as reviewed by Sabatier, 1987b) in evaluating policy areas involving many public and private organizations, concluded that program success was more dependent upon the skills of the individuals in local agencies than upon the efforts of central government officials.

This same 'bottom up' perspective can be applied to individual organizations. Although organizational research has traditionally assumed organizations to be heavily influenced by their leaders, Hage and Dewar (1973) found that the beliefs of individuals who reported high levels of participation in strategic decisions were more predictive of innovative performance than the beliefs of the organization's formal leadership. Fairweather and colleagues (1974), in disseminating the Lodge program for people with mental illness, discovered that high social-organizational status of the person who is contacted by the change agent was relatively unrelated to whether or not actual change occurred. In actuality, contact with lower status agency personnel was related to greater implementation. In other words, the person at the top of the authority structure in an organization does not necessarily have omnipotent power in determining program innovation and implementation. Beliefs of all those in decision making roles are more important in determining an organization's performance than the formal leadership alone.

Therefore, both the formal status of stakeholders and their perceived level of involvement in decision-making regarding the implementation and provision of family support services was determined. Analyses were conducted to determine the extent to which attitudes, beliefs and intentions were correlated with stakeholders' status and levels of decision making involvement. Further, analyses were conducted in order to determine whether the predictive value of attitudes, beliefs and intentions to observed variations in

family support configurations was moderated by status and levels of decision making. As would be hypothesized by the 'top down' perspective, a significant moderator effect would be indicative of the higher importance of the attitudes and beliefs of administrators and highly involved decision makers to the implementation of family support services.

Relative Importance of Organization, Context and Individual Characteristics

The arguments and literature thus far presented suggest that organizational performance is determined by characteristics of the organization and it's environment, and characteristics of people in the organization, their attitudes and beliefs and their relative status in the organization. A number of variables within each of these categories (organization, context, and individual factors) have been empirically evaluated and found to be related to innovation adoption and/or implementation. There is little evidence, however, which suggests which variables are most relevant in the prediction of implementation configurations. Few studies have included variables within all three categories.

Baldridge and Burnham's (1975) research regarding organizational innovation included measures of all three categories. However, although individual characteristics, such as age, sex, cosmopolitanism and education were measured, they were not included in comparison analyses. Also, administrative positions and roles, which were argued to have an impact on perceptions of innovativeness, were not evaluated in regards to actual implementation practices. The methodology and analysis strategy did not allow for a determination of the relative importance of the three categories, as only organizational and environmental characteristics were used as predictors of innovation. Also, individual attitudes and beliefs regarding change or the innovation were not evaluated.

Kimberly & Evanisko (1981) also evaluated the influence of individual, organizational and environmental factors on adoption of innovations. Their research concluded that organizational level variables were the best predictors of innovation (correlation coefficients ranged from .15 to .39). Their research also suggested that different innovation configurations, i.e., technological and administrative, were influenced by different sets of

variables. However, similar to Baldridge and Burnham (1975), the individual level variables evaluated did not include attitudes and beliefs of organizational personnel in regard to change or the particular innovations studied.

In contrast, Hage and Dewar's (1973) research, which focused on individual and organizational variables, did include individual evaluations of change. Their research suggested that individual values (partial correlation coefficients ranged from .70 to .75) were more predictive of innovation implementation than organizational structure (partial correlation coefficients ranged from .32 to .58). They concluded that the values of decision makers "represent a guiding force in the organization, which can change its direction, set policy, and introduce change irrespective of the structural constraints built into the operations of the organization" (p. 286).

In order to add to the literature regarding the relative role of individual versus setting influences in the implementation process, the final hypothesis explored by this research was that beliefs and attitudes of stakeholders would be more predictive of family support configurations than agency and service area characteristics. However, this debate does not take into account the possible joint influence of individual and setting influences on implementation. Research and theory regarding the adoption and implementation of innovative services has suggested that both context and individual characteristics are predictive of implementation. As discussed previously, Lewin's (1951) field theory suggests that behavior, in this case implementation, is a function of both the person and the environment, and, more specifically, the person's perceptions of driving and inhibiting forces within the environment. Arising out of field theory, Ajzen and Fishbein's (1980) theory of reasoned action suggests that behavior is a function of attitudes toward the behavior and the subjective norm for that event (e.g., perceptions of the social pressures for the behavior) which lead to intentions, when then lead to practice. In other words, an individual's attitudes and perceptions of the amount of support in the environment for the behavior informs their decisions regarding whether or not to carry out a particular behavior,

which in turn determines their actions. These two theories help to explain the ecological context in which the implementation of innovations in mental health policy and service delivery occur. When we combine these two theories we can view implementation as a function of three primary forces: driving forces external to the organization, organizational personnel's attitudes toward the innovation, and their perceptions of the internal and external norms for implementation. As suggested by reasoned action theory, the impact of the individual attitudes and perceptions/beliefs on innovation implementation will be mediated by expressed intentions regarding implementation.

Path model. In effect, a path model depicting the implementation of family support services would have three primary paths: agency personnel's perceptions of support from community and peers, their attitudes toward family support, and agency/service area demand characteristics. Further, it is expected that attitudes and beliefs, on average will be correlated in agencies which have more fully implemented family support, since the norm for the behavior will be positive, which in turn helps to facilitate positive attitudes, and vice versa. Likewise, actual demand characteristics and perceptions of demand will be correlated. As shown in Figure 1, the path model which was developed and examined in this research depicted family support configurations (i.e., the number of services and administrative formalization) as a function of agency and context characteristics and agency personnel's attitudes toward family support and their beliefs/perceptions of the subjective norm. Further, the relationship between family support configurations and attitudes and beliefs was hypothesized to be mediated by expressed behavioral intentions regarding the implementation of family support services. The model also depicts expected correlations between attitudes and beliefs, and agency/context characteristics and perceptions regarding the demand for services.

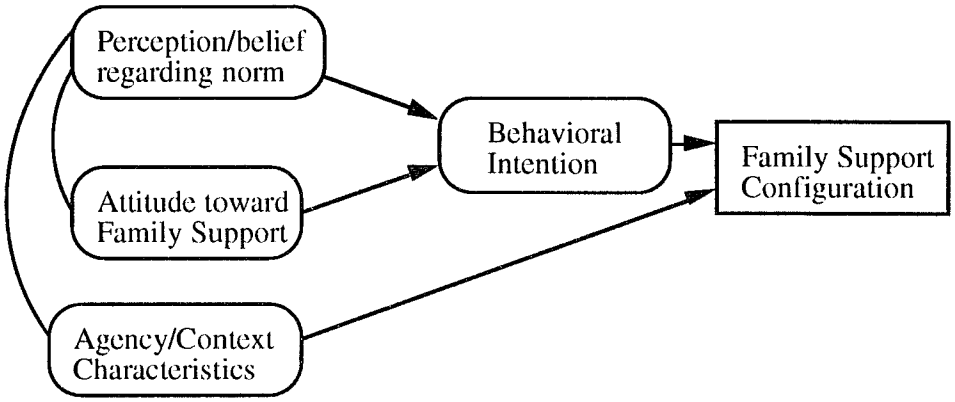

Figure 1

General hypothesized path model of predictors of family support configurations.

Summary

To summarize, family support services are a relatively new and innovative service philosophy and practice within the human services arena. Documented evidence regarding the implementation of family support initiatives within developmental disabilities services has illustrated the wide diversity in service provider practices. Variations in local responses to family support policy have been related to various internal and external organizational characteristics. Little research to date has evaluated the impact of individual characteristics on implementation. By studying the implementation of family support services in Michigan, this research evaluated the hypothesis that both structural characteristics of the organization and its context, and characteristics of organizational personnel are predictive of organizational performance. Specifically, it was hypothesized that larger agency budgets and greater service area population size, density, wealth, and demand would be positively related to more services and greater formalization. Also, positive attitudes toward family

support philosophy and implementation, and perceptions of stakeholders of sufficient agency capacity, and high levels of family and community support, and support from staff and administration would be positively related to higher levels of implementation (i.e., number of services and formalization). Organizational status of stakeholders and their relative levels of participation in decision making regarding family support services were hypothesized to moderate the predictive value of stakeholders' attitudes and beliefs to observed variations in implementation, such that the attitudes and beliefs of stakeholders with a high level of administrative status and decision making involvement would be predictive of more services and greater formalization. It was also hypothesized that stakeholder characteristics would be more predictive of configurations than agency and service area characteristics. And, finally, a theoretically driven path model was developed to describe the hypothesized relationship between innovative behavior and structural characteristics of the organization and its context along with characteristics of organizational personnel.

CHAPTER 2

Method

Organization and Design of the Study

The primary purpose of this study was to evaluate the general hypothesis that organizational performance is determined by structural characteristics of the organization and the context in which it operates, and by characteristics of organizational personnel. In doing so, this research explored the relative importance of stakeholder attitudes toward family support implementation and their beliefs regarding driving and inhibiting forces, and characteristics of agencies and service areas as predictors of observed variations in the implementation family support services in Michigan. The design of this study was cross-sectional and multivariate. The hypotheses were evaluated using correlational and multiple regression analyses.

The criterion variables were two configurations of family support services: the number of different family support services implemented and the number of administrative components implemented (i.e., formalization). Data were collected from a five year follow-up to a longitudinal evaluation of the implementation of family support services in Michigan's community mental health system (Herman, Thompson et al., 1992) and from a mail survey conducted specifically for this study.

Explanatory variables hypothesized to be predictive of the criteria included individual, organization and service area characteristics. Individual level data consisted of measures, developed for this study, of stakeholders' attitudes toward family support philosophy and implementation, beliefs/perceptions regarding driving and inhibiting forces, their expressed intentions related to the implementation of family support, and their perceived role in

agency decision making. Organization level data included a measure of the organization's size based on the agency's total authorized budget. Service area data were obtained from secondary data sources and included measures of the area's population size, density, wealth, and potential demand for services.

Research Setting

Michigan's community mental health system is comprised of 55 county-based mental health agencies. Each agency is responsible for serving the community in their service area which can range from 1 to 4 of Michigan's 83 counties. Thirty-nine of the agencies serve single counties.

Family support services are those services which are provided to support families who are caring at home for a family member with a developmental disability. Although the state has issued policy guidelines regarding family support services (MDMH, 1988), each agency is ultimately responsible for determining which of the family support services, if any, they provide and how those services are implemented.

Participants

The participants were the stakeholders in family support services at the 55 community mental health agencies. As stated in the introduction, stakeholders were defined as those staff and administrative personnel who were in a direct decision making line regarding family support services at the agency. They included individuals directly responsible for the delivery and operation of family support services, such as the family support and respite care coordinators, and family support case managers; and those people involved in the management of developmental disabilities services in general (e.g., the developmental disabilities services director and/or life consultation services director). Also included in the stakeholder category were people responsible for decision making for the agency as a whole, such as the executive administration and board committee members.

Directed phone interviewing with family support services personnel, guided by preliminary information gathered by the five year follow-up study, was used to generate a

pool of potential participants for the study. At least one person at each board was identified for each of the following stakeholder categories: family support services personnel, developmental disabilities services administration, agency administration, and board chairperson. In larger agencies, the family support services personnel category may have included more than one individual, such as a family support services coordinator, a respite care coordinator, and/or a family support case manager. The developmental disabilities services administration and agency administration categories also may have included more than one individual depending upon the hierarchical nature and line of decision making at the agency. The resulting pool of participants included 442 individuals: 237 administrators, and 205 staff.

Response Rate. Of the 442 surveys sent out, 347 (79%) were returned, 8 of which were returned unanswered or were otherwise not usable. As shown in Table 3, a higher percentage of staff than administrators returned the survey. Of the administrators, developmental disabilities services directors had the highest percentage response, followed by agency executive level administrators. Board chairpersons had the lowest response rate.

Table 3: Response rate.

Stakeholders	Recruited *N*	Responded %
Board chair or member	55	51
Executive level administration	78	64
Services level administration	104	77
Total administration	237	67
Total services level staff	205	87
Total overall	442	79

Response rates also varied across agencies (see Table 4). Overall, 78% of the agencies had more than 60% of their potential participants respond to the survey. Comparisons (two-tailed *t*-tests) between agencies with 60% or more and less response rates were made to determine if there was any potential bias associated with the variability in response rates. Agency response rates were compared based on agency size (budget) and demand for services (subsidy cases), and service area size (population and density) and wealth (average personal income and government spending per capita). As shown in Table 4, analyses failed to detect any significant bias associated with agency characteristics.

Table 4: Agency level response rates and comparisons based on agency characteristics.

Agency Level Response Rates	
Percentage of Participants Responded	Percent of Agencies (*N*=55)
0-59 %	22
60-79 %	31
80-100 %	47

	Stakeholder response rate at agency was:			
	60% or less	More than 60%		
Characteristics	*N*=13 Mean (SD)	*N*=42 Mean (SD)	*t*	2-tail probability
Budget ($ mil.)	5.2 (4.2)	13.3 (38)	-.76	n.s.
Demand (subsidy cases)	45.5 (65)	77.4 (136)	-.81	n.s.
Service area population (per 1000)	117 (188)	185 (357)	-.65	n.s.
Service area density	193 (394)	247 (552)	-.33	n.s.
Average personal income ($1000)	13.6 (2)	14 (3)	-.51	n.s.
Per capita government spending ($)	1831 (378)	1642 (316)	1.80	n.s.

Respondent characteristics. As shown in Table 5, 29.7% of the participants indicated that they were directly involved in family support services provision or administration. A minority of participants (20.1%) identified themselves as services staff, but, in their view, were not directly involved with "family support". Most of the participants (50.1%) identified themselves as program or agency administration (board members included).

Table 5: Participants' current position at agency.

Position	Participants (*N*=339)
Board committee chairperson or member	8.4%
Community mental health agency or affiliate administration	19.5%
Service Program administration	22.2%
Family Support Services administration	6.3%
Family Support Services staff	23.4%
Services staff (not family support)	20.1%

Most (80%) of the participants had been employed with the agency for more than three years (see Table 6), and most (61%) had been in their current position within the agency for more than three years (see Table 7). Slightly more than half of the participants (51%, *N*=174) indicated that they had a caseload of clients or families for which they were responsible. Of these, 77% indicated that their caseloads consisted entirely of individuals

Table 6: Participants' length of time at agency.

Length of time at agency	Participants (*N*=339) %
Less than one year	5
1 to 2 years	14
3 to 5 years	25
6 to 10 years	24
More than 10 years	31

Table 7: Participants' length of time in current position.

Length of time in position	Participants (*N*=339) %
Less than one year	10
1 to 2 years	27
3 to 5 years	33
6 to 10 years	17
More than 10 years	11

with developmental disabilities or their families. A small percentage of participants (13%) indicated that members of their immediate family had a developmental disability.

Procedures

A mail survey was developed to measure attitudes, beliefs, and other characteristics of family support stakeholders (see Appendix A). The survey, a cover letter introducing the study, and support letters from MDMH were sent to identified stakeholders in March 1992. A follow-up reminder letter was sent one week later. A second reminder letter was sent two weeks following the initial survey to those participants who had not returned their survey. A third follow-up letter and a second copy of the survey were sent approximately four weeks following the initial survey mailing to non-respondents.

Code numbers were used to keep track of survey returns. Only the study director had access to the coding system which was destroyed at the completion of the data collection phase. In accordance with the American Psychological Association's ethical guidelines (APA, 1992) regarding the involvement of humans in social science research, participants were assured in the survey cover letter that their answers were confidential. The cover letter also explained that their participation was strictly voluntary. The study was approved by the University's Committee on Research Involving Human Subjects (UCRIHS) prior to data collection (see letter in Appendix B).

Measurement

In the survey, participants were asked to indicate what services and activities their agency provided to support families (see question 1 of survey in Appendix A). Participants were also asked to answer questions about themselves, such as the length of time they had worked for the organization, their current position, whether or not they had a caseload of families for which they were responsible, and if they had a family member with a developmental disability (questions 10 through 14).

The majority of the questions on the survey measured attitudes, beliefs/perceptions and behavioral intentions of participants. Items for the belief/perception questions were

generated by a review of responses to open-ended questions regarding the growth promoting and inhibiting factors of family support services from the five year follow-up study (Herman, Thompson, et al., 1992). Experts in the field and the literature regarding family support were consulted for service principles and philosophical themes for the attitude measurements. In general, question items assessed five attitude/belief/intention domains: beliefs/perceptions regarding the forces which inhibit or encourage the implementation of family support services (question 4), perceptions of others' acceptance of family support (question 3), preferences for change, such as expansion and improvement of services (question 2 and 4), attitudes toward family support (question 2), and perceived degree of involvement in agency decision making regarding family support services (questions 6 through 9). All attitude/belief/intention questions were written in a Likert-type format (Likert, 1932) with five response categories. This allowed for the items to be further combined into summated scales (Ghiselli, Campbell & Zedeck, 1981).

Criterion variables. Two criterion variables were used. The first was the number of administrative components implemented which provided a measure of the degree of formalization of family support services at the agency. Data for this variable were obtained directly from results of the five year follow-up study (Herman, Thompson, et al., 1992). This 'baseline' survey was completed by the person at each board who was most familiar with the board's implementation of family support services. In most cases, the respondent was the family support coordinator.

Three administrative components were used to measure the extent to which the agencies had formalized/routinized family support services: the presence of a "formally recognized family support program", the presence of a "single line item budget" for respite care, and the existence of a "formalized committee which served as a link between the agency and families of persons with a developmental disability" (i.e., a parent advisory committee). Agencies were given one point for each component, for a range of scores from 0 to 3.

The second criterion was a measure of the number of family support services the agencies had implemented. Data for this criterion were obtained from the attitude survey. Specifically, in the first open-ended question of the survey, participants were asked to indicate "what services and activities their board/agency currently provided to support families who are caring at home for their member(s) who have a developmental disability?" Answers were coded into 45 categories of service provision. See Table C-1 in Appendix C for results of this question.

Often, staff and administrative personnel who were not directly involved in family support services identified non-family support services. Therefore, many of the services listed had not been previously listed as 'family support' in Department policy or by advocates of family support. In order to maintain content validity, only those services which had been previously identified as family support and thus included in evaluations of family support services were utilized in the 'services' criterion variable. Services included in the measure were case management, respite care, family friend respite, parent education, family support newsletter, family support groups, family networking, family counseling, in-home nursing, behavior management training, specialized therapies, adaptive equipment, home renovations, recreation or campership programs, day care, and shared parenting. A service was counted if at least one family support services staff or administrative person identified it as provided at their agency. Agencies were given one point for each service identified, for a range in scores from 0 to 16.

In order to assess the validity of the services criterion measure, results were compared with information provided by the baseline survey conducted one year earlier. It must be noted that these reports differed not only in time of assessment, but also in the procedures used to collect the data. The attitude survey used a single question open-ended format, while the baseline survey used a closed-ended, multiple question format to obtain yes or no answers on specific services provided by the agencies. Responses to the present attitude survey were coded, when possible, to be comparable to categories established by the earlier

baseline survey. The results from each survey were summed as a frequency count of the number of family support service components, from 0 to 16, implemented at each of the agencies. The correlation between the scores was .64 ($p < .001$). Given the differences in data collection and timing, the remarkable similarity in responses supports the validity of the criterion measure used for this study.

Agency and service area descriptors. Data pertaining to the characteristics of the agency and its service area (i.e., context) were obtained from several sources. First, measures of agency size were based on the agencies' overall budget. Budget allocation information for fiscal year 1989-1990 was obtained from the Michigan Department of Mental Health for each of the agencies.

Second, the number of families receiving the family support subsidy was used to determine the potential demand for family support services at each of the agencies. The subsidy enrollment data for fiscal year '89-90 were obtained from the Department of Mental Health's Family Support Subsidy office. These data are highly reliable and are an exact count of the numbers of families who received the family support subsidy. At a minimum, these are the families who are most eligible for family support services. Families who do not qualify for the subsidy, such as families with adult members who are disabled or whose member has a non-qualifying school assessment (other than SXI, SMI, AI), are also eligible for family support services. However, accurate and comparable data regarding these families are not available (e.g., school district service areas do not coincide with mental health agency service areas). Consequently, the subsidy data were utilized as a proxy measure of the demand for family support services, with a realization that the demand is most likely much greater. The amount of underestimation should be similar across agency service areas.

Third, data pertaining to service area population size, density and wealth were obtained from both the United States' Department of Commerce, Bureau of the Census, and from the Michigan Department of Commerce. All context descriptive data were based on county

statistics aggregated to the agency service area level. Population and square mileage data were obtained from the 1990 census figures. The average personal income of county residents in 1988 and government spending per capita in 1987 were obtained from the Michigan Department of Commerce's (1990) compilation of county descriptive statistics. These data were used to determine the average wealth and government resources of the service area counties. As these data are primarily based on U.S. Census Bureau statistics (according to citations noted in the data book), the reliability of the data is satisfactory (as suggested by Stewart, 1984). Table 8 displays descriptive statistics regarding agency and service area characteristics obtained from secondary data sources.

Attitudes, beliefs/perceptions and behavioral intentions. Stakeholder beliefs/perceptions regarding the forces which inhibit or encourage the implementation of family support services, others' acceptance of family support, their behavioral intentions, and their attitudes toward family support philosophy and implementation were measured by the mail survey. In order to reduce the overall number of variables, responses to 27 attitude and 31 belief/perception items (see Table C-2 through C-4 in Appendix C for item

Table 8: Agency and service area descriptive statistics.

			Distributions	
Characteristics	Mean	SD	low	high
Agency budget ($ mil.)	11.33	33.38	4.82	248.68
Demand (subsidy cases)	70	123	2	805
Service area population (per 1000)	169	325	5.76	2111
Area population density	234	516	6.37	3433
Area avg. personal income ($)	13,930	2663	9196	24,448
Area government spending per capita ($)	1686	338	971	2485

N=55

descriptive statistics) were aggregated into a smaller number of scales utilizing standard scale development techniques (as suggested by DeVellis, 1991). First, all items were submitted to an exploratory factor analysis (i.e., principal axis factoring with varimax rotation) in order to identify common factors underlying the individual items. The results yielded 13 factors with eigenvalues greater than 1 which accounted for 61% of the variance. These results also indicated that the attitude items formed 6 factors and the belief/perception items formed 7 separate factors. Therefore, in further analyses the attitude items were submitted independently of the belief/perception items.

Varimax rotated factor loadings from principal axis factoring were used to identify potential items for each scale. Items which loaded .4 or higher on each factor were grouped together. Items which did not load highly on a single factor were deleted and the factor analysis was repeated. In the course of two analysis runs, 4 attitude items and 4 belief/perception items were deleted for these reasons (as indicated in Tables C-5 and C-6 in Appendix C). Tables 9 and 10 display the final results of the exploratory factor analyses. The five attitude factors accounted for 57% of the variance prior to rotation. All items loaded singly on one factor except for two items in the first attitude factor that also loaded highly on the second factor. The six belief/perception factors accounted for 61% of the variance prior to rotation. However, since no items loaded highly on the sixth belief/perception factor, this factor was disregarded.

Confirmatory factor analytic techniques (as suggested by Hunter, 1980) were utilized to further determine the factor structure of the two sets of items. Item-factor and inter-item correlation analyses were utilized to determine the best item to factor inclusion (item homogeneity) and, thereby, scale content validity (as suggested by Ghiselli, Campbell & Zedeck, 1981). Examination of inter-item and item-factor correlations suggested that the two attitude items which had double loadings in the exploratory analysis were highly intercorrelated with and thus, better placed with two items of the second factor (items identified with an ^ in Table 9) to form a sixth attitude factor (see Table 11). Further, two

Table 9: Final principal axis factoring of attitude items after varimax rotation.

	Factors				
Factor statistics	I	II	III	IV	V
Eigenvalue (before rotation)	7.3	1.9	1.4	1.3	1.2
Percent of variance (after rotation)	29.5	6.0	3.5	3.1	2.6
Items (abbreviated)					
Don't think there is a need for FSS	.71	-.25	-.14	.05	.13
Not convinced FSS is effective or appropriate	.67	-.31	-.05	.12	.20
Like to see agency discontinue FSS	.57	-.17	-.09	.07	.10
Families have help from others, mental health should not be using resources too	.52	-.03	-.28	.24	.32
Not strong enough need to warrant further development of FSS	.52	-.26	-.39	.11	.10
^Parents views are important to services planning	-.49	.45	.12	-.09	-.03
^Parents should be actively involved in services planning	-.46	.42	.14	-.17	.04
Family support takes up too much staff time better devoted to other services	.41	-.37	-.27	.25	.26
^Parents are knowledgeable and competent resources	-.19	.57	.08	.02	-.03
Family support concepts should be agency's way of doing business	-.32	.50	.21	-.19	-.12
Supporting families should be top priority at agency	-.23	.48	.29	-.29	-.10
Services more effective when family centered and driven	-.16	.48	.12	-.12	-.07
Personally committed to FSS	-.20	.47	.38	.08	-.19
^Families not capable care givers (R)	-.19	.46	.05	-.26	-.18
Like to help others implement FSS	-.09	.40	.24	-.09	-.08

Table 9 (cont'd).

	Factors				
Items (abbreviated)	I	II	III	IV	V
Agency should redirect resources to provide more FSS	-.08	.07	.75	-.17	.01
FSS should be greater percentage of agency budget	-.23	.19	.66	-.13	.04
Staff resources should be redirected, more emphasis on FSS	-.08	.27	.61	-.18	.00
Would like to see agency expand or improve FSS	-.36	.28	.46	.16	.09
Focus on person with disability, not family	.11	-.12	-.19	.62	-.07
Services for individuals priority over services for family	.09	-.12	-.07	.49	.15
FSS require too much change	.09	-.21	.09	-.03	.68
Agency should find out more about FSS before going further	.15	-.03	-.02	.10	-.48

(R) identifies items which were reverse scored for factor analysis

^ identifies items which formed a sixth factor in confirmatory analyses.

Table 10: Final principal axis factoring of belief/perception items after varimax rotation.

	Factors					
Factor statistics	I	II	III	IV	V	VI
Eigenvalue (before rotation)	7.7	2.6	2.2	1.6	1.3	1.0
Percent of variance (after rotation)	26.9	7.8	6.0	4.0	2.7	1.8
Items (abbreviated)						
Board committee members are supportive	.77	.22	.07	-.06	.21	.24
Board committee members committed to develop/expand FSS	.74	.03	.06	.22	.06	-.13
Agency's administration is committed to develop/expand FSS	.74	.11	.02	.21	.09	-.12
Board chairperson is supportive	.74	.24	.03	.03	.11	.30
Agency's executive director is supportive	.73	.33	.11	.05	.08	.09
Agency's top administration is supportive	.72	.39	.08	-.01	.06	.12
People at agency are not interested in providing FSS (R)	.63	.19	-.03	.13	.19	.02
Providing FSS is a top budget priority	.58	-.00	.14	.31	.09	-.12
People at agency lack clear understanding of FSS (R)	.45	.11	.03	.19	.27	-.12
Self is supportive of FSS	.11	.74	.06	.11	-.12	.06
Agency's developmental disabilities staff is supportive	.22	.74	.06	-.02	.19	-.17
FSS staff is supportive	.13	.73	-.03	.11	.05	-.09
Professional peers are supportive	.14	.68	-.07	.14	.16	.06
Staff supervised are supportive	.18	.64	.05	.14	.17	.22
Developmental disabilities administration is supportive	.46	.59	.16	-.15	.09	-.07
Immediate supervisor is supportive	.28	.47	.07	.21	-.09	.29
Agency lacks funding capacity (R)	.04	.11	.67	.09	.01	-.03
Agency has sufficient capacity	.07	-.02	.65	-.07	.09	.10
Agency lacks sufficient staff (R)	.12	.02	.59	-.03	.06	-.11
Agency not able to keep up with demand, families wait (R)	-.04	-.02	.44	-.38	.02	.09

Table 10 (cont'd).

Items (abbreviated)	Factors I	II	III	IV	V	VI
Community agencies refer families to agency for services	.17	.09	-.07	.52	-.07	.13
Families reluctant to take advantage of services available (R)	.05	.15	-.08	.48	.13	.01
Families active in advocating for FSS	.21	.01	.09	.43	.14	-.10
Families don't want FSS (R)	.01	.38	-.01	.41	.21	.06
Attitudes and practices in community support individual services, not family services (R)	-.16	-.14	-.03	-.13	-.61	-.22
System does not recognize family as client (R)	-.27	-.00	-.15	.05	-.44	.05
Lack of community interest in supporting individuals and families (R)	-.12	-.13	-.05	-.17	-.44	.13

(R) identifies items which were reverse scored for factor analysis.

of the belief/perception items which were originally deleted were found to be highly inter-correlated. These two items were thus combined to form one of two behavioral intention factors (see Table 12). The other behavioral intention factor was formed by items in factor III of the attitude item analysis (see Table 13). And last, after examining inter-item and item-factor correlations, one item which was originally deleted from the fourth belief/perception factor was returned (see item 5 in Table 14). Confirmatory analysis indicated that all other item-factor and inter-item correlations were consistent with expected patterns (high item-factor and inter-item correlations, and low item to other factor correlations), thus no other changes were made to the factors obtained during the exploratory stage.

The resulting 12 factors (4 attitude, 5 belief/perception, 3 intentions) were then submitted to internal consistency reliability analysis using Cronbach's alpha (Cronbach, 1951). Three factors (1 each of attitude, belief/perception, and intention) failed to achieve reliability estimates greater than .60 and were thus deleted (see Table C-7 in Appendix C for results of internal reliability and confirmatory analyses of deleted factors). Tables 11 through 19 present inter-item correlations and item-total correlations (i.e., results of confirmatory analyses) for each of the nine remaining scales. Table 20 and 21 present summaries of the reasons for dropping items from the factor analyses and resultant scales (see Table C-8 for correlations between these items/factors and the criterion variables).

Scale scores were computed as the average rating of the items in the factor, and ranged from 1 to 5. Table 22 presents means, standard deviations and internal reliability for each of the scales. Three attitude scales measured participants' attitudes toward family support services and philosophical themes. Specifically, the support for parent involvement in service/agency decision making scale (see Table 11) measured attitudes toward the core philosophy of family support of parents as competent resources and parent empowerment in decision making. Items in the positive attitudes toward family support scale (see Table 16) measured personal commitment to implementing family support along with attitudes

Table 11: Parent involvement in services planning attitude scale.

Items (abbreviated)	Inter-item correlations 1	2	3	Corrected Item-total *r*
1. Parents views are important to services planning				.52
2. Parents should be actively involved in services planning	.55			.48
3. Parents are knowledgeable and competent resources and should be involved	.39	.34		.48
4. (R) Families not capable care givers	.29	.29	.38	.42

(R) indicates items in this scale which were reverse scored.

Table 12: Agency commitment to hiring and training staff for family support services (FSS) behavioral intention scale.

Items (abbreviated)	Inter-item correlation 1	Corrected Item-total *r*
1. Agency provided FSS staff training opportunities		.55
2. Agency hired staff with FSS expertise	.55	.55

Table 13: Expansion and improvement of family support services (FSS) behavioral intention scale.

Items (abbreviated)	Inter-item correlations 1	2	3	Corrected Item-total *r*
1. Agency should redirect resources to provide more FSS				.65
2. FSS should be greater percentage of agency budget	.58			.65
3. Staff resources should be redirected to put more emphasis on FSS	.59	.42		.57
4. Would like to see agency expand or improve FSS	.31	.52	.32	.46

Table 14: Family and community support for family support services (FSS) belief scale.

Items (abbreviated)	Inter-item correlations 1	2	3	4	Corrected Item-total *r*
1. Families active in advocating for expansion/development of FSS					.34
2. (R) Families reluctant to take advantage of services available	.17				.42
3. Community agencies refer families to agency for services	.21	.38			.36
4. (R) Families don't want FSS	.22	.42	.27		.46
5. Sufficient resources in community to support agency's efforts to provide FSS	.31	.20	.14	.30	.35

(R) indicates items in this scale which were reverse scored.

Table 15: Agency capacity to provide family support services (FSS) belief scale.

Items (abbreviated)	Inter-item correlations 1	2	3	Corrected Item-total *r*
1. Agency has sufficient capacity				.53
2. (R) Agency lacks funding capacity	.46			.49
3. (R) Agency lacks sufficient staff	.36	.44		.43
4. (R) Agency not able to keep up with demand, families have to wait	.32	.18	.18	.28

(R) indicates items in this scale which were reverse scored.

Table 16: Positive attitude toward family support services (FSS) scale.

Items (abbreviated)	Inter-item correlations 1	2	3	4	Corrected Item-total *r*
1. Family support concepts should be agency's way of doing business					.56
2. Supporting families should be top priority at agency	.47				.55
3. Like to help others implement FSS	.35	.36			.43
4. Personally committed to FSS	.39	.38	.33		.50
5. Services more effective when family centered and driven	.39	.35	.21	.33	.46

Table 17: Negative attitude toward family support services (FSS) scale.

Items (abbreviated)	Inter-item correlations 1	2	3	4	5	Corrected Item-total *r*
1. Don't think there is a need for FSS						.69
2. Not convinced FSS is effective or appropriate	.63					.66
3. Like to see agency discontinue FSS	.50	.43				.54
4. Families have help from others, mental health should not be using resources too	.45	.49	.39			.60
5. Do not see strong enough need to warrant further development of FSS	.52	.48	.44	.45		.62
6. Family support takes up too much staff time better devoted to other services	.49	.48	.35	.52	.40	.61

Table 18: Perception of staff support for family support services (FSS) scale.

Items (abbreviated)	Inter-item correlations 1	2	3	4	5	6	Corrected Item-total *r*
1. Self is supportive of FSS							.67
2. FSS staff if supportive	.61						.63
3. Agency's developmental disabilities staff is supportive	.54	.59					.72
4. Professional peers are supportive	.46	.46	.62				.65
5. Staff supervised are supportive	.47	.48	.46	.46			.59
6. Developmental disabilities administration is supportive	.47	.46	.62	.44	.40		.59
7. Immediate supervisor is supportive	.38	.23	.29	.39	.35	.28	.42

Table 19: Perception of administrative support for family support services (FSS) scale.

Items (abbreviated)	Inter-item correlations 1	2	3	4	5	6	7	8	Corrected Item-total *r*
1. Board committee members are supportive									.78
2. Board committee members committed to develop/expand FSS	.58								.71
3. Board chairperson is supportive	.84	.55							.76
4. Agency's administration is committed to develop/expand FSS	.55	.68	.58						.72
5. Agency's executive director is supportive	.68	.52	.68	.52					.74
6. Agency's top administration is supportive	.73	.52	.71	.55	.83				.76
7. (R) People at agency not interested in providing FSS	.57	.46	.58	.52	.56	.55			.66
8. Providing FSS is a top budget priority	.46	.62	.44	.61	.42	.45	.51		.62
9. (R) People at agency lack clear understanding of FSS	.39	.44	.39	.39	.40	.37	.39	.37	.49

(R) indicates items in this scale which were reverse scored.

Table 20: Attitude items dropped from scales.

Attitude item	Reason for dropping
I feel that programs and services for people with disabilities should take priority over support services for families	Internal reliability (alpha) of attitude factor IV which contained item was .55, below criteria of .60 for scale construction.
Family support services require too much change in the way my board/agency provides services to our clients	Internal reliability (alpha) of attitude factor V which contained item was .54, below criteria of .60 for scale construction.
There are needs in our community that are much more pressing which should be addressed first, before we develop family support services any further.	Formed separate factor in initial factor analysis, did not load strongly on other factors, deleted from final factor analysis.
I feel that the focus of services should be on the person with disabilities, not the family	Internal reliability (alpha) of attitude factor IV which contained item was .55, below criteria of .60 for scale construction.
Many activities and services related to family support are not within the domain of mental health responsibility, other service providers should be providing these supports	Item failed to load highly on any factors in initial factor analysis, deleted from final factor analysis.
I think my agency should find out more about family support services before we go any further	Internal reliability (alpha) of attitude factor V which contained item was .54, below criteria of .60 for scale construction.
I would like to know what other agencies are doing in regard to family support services	Item failed to load highly on any factors in initial factor analysis, deleted from final factor analysis.
Since most families with children with disabilities are supported by the school system, it is not necessary for mental health to also provide services for them.	Item failed to load highly on any factors in initial factor analysis, deleted from final factor analysis.

Table 21: Belief/perception items dropped from scales.

Belief/perception item	Reason for dropping
State Department funding allocations have helped my agency's ability to provide family support services.	Item failed to load highly on any factors in initial factor analysis, deleted from final factor analysis.
There is a general lack of community interest and involvement in supporting individuals with disabilities and their families	Internal reliability (alpha) of belief factor V which contained item was .47, below criteria of .60 for scale construction.
The system does not recognize the family as the client, only the individual with disabilities, which hinders our efforts to implement support services for families	Internal reliability (alpha) of belief factor V which contained item was .47, below criteria of .60 for scale construction.
The attitudes and practices of most service providers in our community are that support services should be provided only to the individual with disabilities, they do not involve or support the family	Internal reliability (alpha) of belief factor V which contained item was .47, below criteria of .60 for scale construction.

Table 22: Attitude, belief/perception and behavior intention scale statistics.

	# Items	Alpha	Mean(SD)	Mean Inter-item *r*
Attitude scales				
Negative attitudes toward FSS	6	.84	1.60(.48)	.47
Parent involvement in planning	4	.70	4.21(.55)	.37
Positive attitudes toward FSS	5	.74	4.03(.58)	.36
Behavioral intention scales				
Expansion and improvement of FSS	4	.77	3.76(.66)	.46
Agency commitment	2	.71	3.63(.96)	.55
Belief/perception scales				
Administrative support	9	.91	3.69(.72)	.54
Staff support	7	.85	4.52(.52)	.45
Agency capacity	4	.65	2.26(.85)	.32
Family/community support	5	.64	3.45(.66)	.26

Table 23: Attitude, belief/perception and behavior intention inter-scale correlations corrected for attenuation.

	Corrected zero-order correlations							
Attitude scales:	1	2	3	4	5	6	7	8
1. Negative attitudes to FSS								
2. Parent involvement	-.78							
3. Positive attitudes to FSS	-.76	.85						
Behavioral intention scales:								
4. Expansion and improvement	-.58	.53	.69					
5. Agency commitment	-.28	.20	.40	-.20				
Belief/perception scales:								
6. Administrative support	-.14	.10	.21	-.24	.62			
7. Staff support	-.54	.36	.43	.19	.40	.55		
8. Agency capacity	.03	-.04	-.10	-.30	.26	.14	.11	
9. Family/community support	-.31	.12	.42	.10	.65	.47	.34	-.02

N=339

favoring core family support concepts such as family centered and driven services. Items in the negative attitudes toward family support scale (see Table 17) focused on the extent to which participants disapproved of family support implementation, possibly because they did not see a need for services, or were not convinced that family support was effective, or that resources would be better used for other services. The means of the attitude scales suggested that the distribution of scores was somewhat skewed to the positive end of the scale.

Two measures of behavioral intentions were developed, one associated with attitude items and one associated with belief/perception items. The support for expansion and improvement of family support services scale (see Table 13) measured preferences for redirecting resources to provide more family support services. The second behavioral intention scale measured perceptions of activities which have been carried out by the agency which support the implementation of family support, such as hiring and training staff for family support services (see Table 12).

The four belief/perception scales measured stakeholders' awareness of the internal and external forces which drive or inhibit family support services implementation. Beliefs/perceptions regarding external forces were measured by the family and community support for family support services scale (see Table 14). Belief/perceptions regarding internal forces were measured by three scales, one which dealt with capacity issues (see Table 15), and two which dealt with the subjective norm in the agency, i.e., support from staff (see Table 18) and support from administration (see Table 19). Similar to the attitude scales, the distribution of one of the belief/perception scales, staff support, was somewhat skewed toward the highly supportive end of the scale.

Table 23 presents zero-order correlations corrected for attenuation between the nine scales. In general, corrected correlations among the scales ranged from .02 to a high of .78. The attitude scales were more highly inter-correlated than the belief scales. The two behavioral intention scales were negatively correlated.

Role and decision making status. Survey participants identified their role within the agency (question 11 of the survey). Responses to this question were condensed into an index of role status which included three levels: staff (50%), direct services administration (22%), and agency level administration (28%). This variable was treated as an ordinal scale measuring participants' role status from lowest (staff = 1) to highest (agency administration = 3).

Participants were also asked a series of four questions concerning their perceived involvement in decision making at the agency. Two questions concerned the participants' perceptions of their impact on, and frequency of participation in "overall planning and implementation of services" at their agency. The other two questions explored their perceived impact on, and frequency of participation in decisions regarding "services and supports to individuals with disabilities and their families" at the agency. Table 24 displays the results concerning respondents' reported role in decision making at the agency.

The four impact and frequency items were highly inter-correlated and, thus, were combined into one 'Decision Making Status' scale score. The items were summed and the mean calculated for the scale score. The alpha for this scale was .88, the mean inter-item correlation was .64, and the corrected item-total correlations ranged from .59 to .80. The overall scale mean was 3.25 (SD = 1.14).

Table 24: Participants' perceptions of their role in agency decision making.

		% Response				
		Very little	Little	Some	Much	Very much
Impact on:	Mean (SD)	1	2	3	4	5
overall services planning	2.99 (1.47)	25	14	21	20	21
DD services planning	3.34 (1.29)	12	13	26	26	23
Frequency of participation in:	Mean (SD)	Never 1	Seldom 2	Sometimes 3	Often 4	Always 5
overall services planning	3.09 (1.37)	16	23	17	25	20
DD services planning	3.59 (1.16)	7	12	19	39	23

$N = 339$

CHAPTER 3

Results

The percent of agencies where at least one respondent reported family support services is shown in Table 25. Similar to previous findings (Herman, Thompson et al., 1992), respite care and case management were provided by almost all agencies, and daycare and shared parenting were least often provided. The number of services provided at the agencies ranged between 1 and 14, the mean and mode was 7 with a standard deviation of 3.

In regard to the level of formalization of services, 20% of the agencies had implemented all three indicators (i.e., program structure, respite budget, parent advisory council), 38% had implemented two indicators, 29% had implemented one indicator, and 13% had not implemented any of the indicators of administrative formalization. The average level of formalization was 1.66 with a standard deviation of .95.

Hypotheses 1 and 2: Agency and Service Area Predictors

The first hypothesis stated that organizational size would be positively correlated with higher levels of family support services implementation. Pearson correlational analyses were used to test this hypothesis with agency budget used as an indicator of agency size. As can be seen in Table 26, agency budget was significantly positively correlated with the number of family support services provided, but not with the degree of formalization of family support within the agency. Thus, larger budgets were related to more services, but not necessarily with a higher level of formalization. It should be noted that the number of different services was positively correlated with formalization ($r = .36$, $p < .01$),

Table 25: Percent of agencies where respondents indicated provision of services.

Service	Percent of agencies (*N*=55)
Case management	96
Respite Care	100
Family Friend Respite	53
Parent Education	55
Family Support Groups	38
Parent-parent Network	35
Newsletter	26
Family Counseling	67
In-home Nursing	24
Behavior Management Training	69
Special Therapies	22
Adaptive Equipment	51
Home Renovations	33
Recreation or Campership	44
Daycare	9
Shared Parenting	2

suggesting that agencies with more services had implemented more formal administrative structures.

The second hypothesis stated that service area characteristics (i.e., population, demand, density, average personal income, and average government spending per capita) would be positively correlated with higher levels of family support services implementation. Pearson correlational analyses were used to test this hypothesis. These results are presented in Table 26. As predicted, three service area characteristics (i.e., population size, demand, and density) were significantly positively correlated with the number of family support services provided. Larger service area populations, higher levels of population density,

Table 26: Zero-order correlations between agency and service area characteristics and the criteria.

	Zero-order Correlations						
Variables	1	2	3	4	5	6	7
1. Agency budget							
2. Demand (subsidy enrollment)	.90**						
3. Service Area Population	.89**	.98**					
4. Service Area Density	.90**	.96**	.98**				
5. Area Avg. Personal Income	.24*	.48**	.53**	.48**			
6. Service Area Government Spending Per capita	.29*	.28*	.26*	.23*	.13		
7. **# Family Support Services**	**.37****	**.46****	**.39****	**.36****	**.23***	**.06**	
8. **Degree of Formalization**	**.10**	**.19**	**.15**	**.09**	**.03**	**.07**	**.36****

N=55

* $p < .05$, ** $p < .01$, one-tail.

higher demand for services were associated with agencies implementing more family support components. Average personal income and average government spending per capita were not significantly correlated with number of services. Further, none of the service area characteristics were significantly correlated with the degree of formalization. Therefore, hypotheses 1 and 2 were upheld for the services criterion, but not for the administrative formalization criterion. Service area characteristics were significantly correlated with the number of services, but not formalization.

Hypotheses 3 and 4: Attitude and Belief Predictors

The third and fourth hypotheses stated that positive attitudes toward family support philosophy and implementation, and perceptions of stakeholders of sufficient agency capacity, and high levels of family and community support, and support from staff and administration would be positively correlated with family support services configurations.

For these analyses, the scale scores of all stakeholders of an agency were aggregated and the mean computed to establish the agency scale score. Pearson correlational analyses were used to determine correlations between the aggregated attitude, belief/perception and behavioral intention scales and the criteria. Correlation coefficients were then corrected for attenuation and statistical significance determined based on 95% confidence interval estimates. As shown in Table 27, two attitude measures (negative attitudes toward FSS and positive attitudes toward family support) were significantly correlated (i.e., confidence interval did not include 0) in the expected direction with the number of family support services implemented. Higher levels of positive attitudes toward services, and lower levels of negative attitudes toward services were related to greater numbers of services. No attitude measures were significantly correlated with administrative formalization. Thus, the hypothesis that attitudes would be positively correlated with family support configurations was upheld for the services criterion, but not for the formalization criterion.

Regarding beliefs/perceptions, the results presented in Table 27 indicated one belief/perception measure, family and community support, was significantly correlated in the expected direction with the number of family support services provided. This measure, together with perceptions of administrative support for services, was also correlated positively with degree of formalization. Thus, beliefs/perceptions were positively correlated with both of the family support configurations, upholding the third and fourth hypotheses.

Behavioral intentions. As shown in Table 27, preference for expansion and improvement of family support services was positively correlated with number of services. Further, perception of agency commitment was significantly correlated, in the expected direction, with both criteria. Perceptions of the agency's willingness to hire and train staff for family support was related to both a greater number of services provided and more formal administrative structures.

Table 27: Corrected zero-order correlations between attitude, belief/perception, and behavioral intention scales and the criteria.

	Corrected zero-order Correlations (± 95% confidence interval)								
Attitude scales	1	2	3	4	5	6	7	8	9
1. Negative attitudes to FSS									
2. Parent involvement	-.72 (.26)								
3. Positive attitudes to FSS	-.74 (.22)	.93 (.20)							
Behavioral intention scales									
4. Expansion/improvement	-.70 (.22)	.54 (.30)	.76 (.24)						
5. Agency commitment	-.61 (.28)	.45 (.34)	.69 (.28)	.05 (.38)					
Belief/perception scales									
6. Administrative support	-.11 (.30)	.04 (.36)	.09 (.34)	-.44 (.28)	.55 (.28)				
7. Staff support	-.64 (.24)	.45 (.32)	.47 (.30)	.11 (.32)	.68 (.26)	.53 (.26)			
8. Agency capacity	-.04 (.38)	.10 (.42)	.04 (.40)	-.08 (.40)	.32 (.38)	-.16 (.34)	.11 (.38)		
9. Family/community support	-.57 (.30)	.16 (.38)	.71 (.30)	.48 (.34)	.73 (.30)	.30 (.34)	.42 (.32)	-.22 (.40)	
Criterion									
#Family Support Services	**-.34** (.28)	**.30** (.32)	**.41** (.28)	**.32** (.30)	**.44** (.28)	**.21** (.28)	**.23** (.28)	**-.19** (.32)	**.60** (.26)
Degree of Formalization	**-.20** (.28)	**.12** (.32)	**.21** (.30)	**-.11** (.30)	**.50** (.26)	**.34** (.26)	**.24** (.28)	**.16** (.32)	**.49** (.30)

N=55

Attitudes, beliefs/perceptions and behavioral intentions related to role and decision making status. Pearson correlations were calculated between attitudes, beliefs/perceptions and behavioral intentions and the status variables. Correlations were then corrected for attenuation and statistical significance was determined based on 95% probability confidence interval estimates. As shown in Table 28, several of the scales were significantly correlated (i.e., confidence intervals did not contain 0) with decision making status and role status. Individuals who indicated greater involvement in decision making were more likely to report positive attitudes toward family support services and parent involvement in services planning, perceptions of greater agency commitment, greater capacity, greater administrative and staff support for services, and greater family advocacy and community support for services. Decision making was negatively correlated with intentions toward expansion and improvement in family support services, suggesting that people who were more involved in agency decision making were less likely to affirm desires to expand or improve services. This was corroborated by a negative correlation between role status and expansion intentions, suggesting that people who were in higher levels in the agency expressed less positive intentions toward expansion and improvement of services.

Role status was also positively correlated with negative attitudes, suggesting that higher levels of administration expressed more negative attitudes toward family support. However, keep in mind that attitude scales were somewhat skewed in the positive direction and therefore relatively negative attitudes may still in fact be positive in an absolute sense. Role status was also positively correlated with perceptions of greater agency commitment and administrative support. Thus, higher level administrators, although less favorable toward family support philosophy and expansion, expressed perceptions of greater agency commitment to implementing family support services and greater administrative support for services. On the other hand, the same correlations indicate that staff were less likely to

Table 28: Corrected zero-order correlations between decision making status and role status, and attitudes, beliefs/perceptions and behavioral intentions.

	Corrected Zero-order Correlations (± 95% confidence interval)	
	Decision Making	Role
Attitude scales		
1. Negative attitudes to FSS	-.06 (.12)	.17 (.10)
2. Parent involvement in planning	.13 (.12)	-.11 (.12)
3. Positive attitudes to FSS	.21 (.12)	-.03 (.12)
Behavioral intention scales		
4. Expansion/improvement of FSS	-.24 (.12)	-.42 (.12)
5. Agency commitment	.56 (.12)	.27 (.12)
Belief/perception scales		
6. Administrative support	.53 (.08)	.34 (.10)
7. Staff support	.22 (.12)	.01 (.10)
8. Agency capacity	.19 (.14)	.01 (.12)
9. Family and community support	.25 (.14)	.11 (.12)

believe that their agency had hired and trained staff for family support, and were less likely to indicate that administrators were supportive, possibly recognizing administrative reluctance to expand services.

Hypothesis 5: Decision Making and Role Status as Moderator

The fifth hypothesis stated that decision-making status and role status of stakeholders would moderate the prediction of family support configurations from stakeholder attitudes,

beliefs/perceptions and behavioral intentions. A series of multiple regression analyses were conducted in order to test this hypothesis. All analyses for this hypothesis were conducted at the individual level of analysis (as compared with previous analyses which were at the agency level). Pearson correlations, corrected for attenuation, were used to determine the relationship between decision-making status and role status. As would be expected, a higher level of decision making status was highly correlated with a higher administrative role in the agency (corrected $r = .70$). Decision making status and role status were, thus, standardized and the mean of the two scores was used as a single index of status. The status scores were then standardized for the regression analyses. Further, all scales and criteria were standardized.

A series of hierarchical multiple regression analyses were used to test the hypothesis that status moderated the effect of attitudes, beliefs/perceptions and behavioral intentions on the criteria. At the first step in each regression, a variable which identified the person's agency was entered in order to control for any potential effects of similar agency membership. Then the main effects of the attitude, belief/perception or behavioral intention score and the status score were assessed by entering these variables into the equation. Next, interaction terms were calculated by computing the cross-products of the status score with each of the attitude, belief/perception, and behavioral intention scores. These cross-product terms were entered into the regression equations at the third step. Cross-products with significant partial correlations with the criteria, after controlling for all main effects, would be evidence of significant interactions and indicative of moderator effects. As shown in Table 29, only main effects were found to be significantly correlated with the criteria. Main effects of attitudes, beliefs/perception, and intentions were previously discussed. Main effects of status are not interpretable. No significant interactions were found. Thus, the fifth hypothesis, which predicted a moderator effect of status with attitudes, beliefs/perceptions and intentions, was not upheld.

Table 29: Status as moderator: results of regression analyses for hypothesis 5.

	Main Effects		Interaction Effects	
Predictors of Number of Family Support Services	Scale β	Status β	β	R
Attitude scales				
Negative attitudes to FSS	-.22**	-.13*	-.02	.30
Parent involvement in planning	.13*	-.15**	.04	.24
Positive attitudes to FSS	.26**	-.17	.05	.32
Behavioral intention scales				
Expansion/improvement of FSS	.17**	-.09	.04	.26
Agency commitment	.28**	-.24**	.01	.32
Belief/perception scales				
Administrative support	.20**	-.23**	-.02	.26
Staff support	.14**	-.15**	-.11	.26
Agency capacity	-.10	-.13*	.02	.22
Family and community support	.31**	-.19**	.07	.37
Predictors of Administrative Formalization				
Attitude scales				
Negative attitudes to FSS	-.18**	-.03	-.06	.20
Parent involvement in planning	.10	-.05	.04	.14
Positive attitudes to FSS	.20**	-.06	.02	.22
Behavioral intention scales				
Expansion/improvement of FSS	-.00	-.05	-.02	.10
Agency commitment	.34**	-.16**	.10	.32
Belief/perception scales				
Administrative support	.21**	-.14**	.00	.22
Staff support	.19**	-.06	.00	.20
Agency capacity	.03	-.03	.09	.14
Family and community support	.30**	-.09	-.02	.32

* $p < .05$, * $p < .01$.

Overall Predictors of Family Support Configurations

Hypothesis 6: The sixth hypothesis stated that beliefs/perceptions and attitudes would be more predictive of family support configurations than agency and context characteristics. A series of simultaneous entry multiple regression analyses, using a correlation matrix which had been corrected for attenuation, were used to test the hypothesis. First, in order to reduce the number of variables with high inter-correlations in the regression analyses, the demand variable was chosen to reflect the overall population size, density, and demand for services. As was shown in Table 26, demand had the strongest correlations with the criteria and was equally highly correlated with population size (corrected $r = .98$) and density (corrected $r = .96$). Demand was used along with agency budget and service area wealth indicators as agency and context characteristic predictors of the criteria.

Second, separate multiple regression analyses (at the agency level of analysis) were used to determine the most significant predictors from the sets of attitude and belief/perception variables and from the set of agency and context predictors. In conducting the analyses, it became evident that one of the attitude scales, positive attitudes toward family support, although the most highly correlated of the attitude scales with the criteria, was too highly intercorrelated with the other attitude and belief/perception variables. This multi-collinearity resulted in unacceptably small (less than .01) tolerance estimates for this variable. Thus, the item was deleted from the multiple regression analyses.

Regarding the number of different services, Table 30 indicates that beliefs/perceptions regarding family advocacy and community support for services ($\beta = .78, p < .01$) and attitudes toward parent involvement in services planning ($\beta = .53, p < .01$) were the only two attitude and belief/perception variables with significant Beta coefficients. In regard to agency and context predictors of number of services, demand for services ($\beta = .75, p < .05$) was the only significant agency/context characteristic predictor.

Table 30: Predictors of number of family support services. Results of multiple regression analyses.

	Separate Analyses		Combined Analysis	
	β	R	β	R^2 Change
Attitude scales:				
Negative attitudes to FSS	.44			
Parent involvement in planning	.53**		.23*	
Positive attitudes to FSS (tolerance too small for procedure)				
Belief/perception scales:				.27**
Administrative support	.03			
Staff support	-.06			
Agency capacity	-.04			
Family/community support	.78**	.69	.46**	
Agency/context characteristics:				
Agency budget	-.28			
Demand (subsidy enrollment)	.75*	.48	.30**	.08**
Avg. personal income	.06			
Government spending per capita	-.06			

* $p < .05$, ** $p < .01$

In order to determine the relative predictive value between attitude/belief and agency/context variables to the number of services criterion, significant predictor variables were submitted to a second multiple regression analysis. The results of this analysis are shown in the right hand columns of Table 30. This second analysis revealed that both of the attitude and belief/perception variables as well as demand remained as a significant predictors of the number of family support services. The extent to which each construct (i.e., individual versus agency/context variables) uniquely contributed to the prediction was

calculated by determining the increase in R^2 as each set of variables (i.e., the attitude and belief/perception variables combined compared with the demand variable) entered last into the equation. A significant change in R^2 indicates that a variable provides unique information about the criterion that is not available from other independent variables in the equation (Norusis, 1988). Results, as shown in Table 30, indicated that both variables provided significant unique contributions to the regression model. The sixth hypothesis predicted that attitudes/beliefs would be more predictive of the number of different services provided. Because the change in R^2 indicated that attitudes/beliefs independently contributed more to the prediction of the number of services, the sixth hypothesis was supported.

Similar analyses were used to determine predictors of the degree of formalization. As shown in Table 31, perceptions of family and community support for services ($\beta = .75$, $p < .01$) and beliefs regarding agency capacity ($\beta = .33$, $p < .01$) were significant predictors of administrative formalization. Demand was also a significant predictor ($\beta = .85$, $p < .05$). No other agency or service area characteristics were significant predictors. Once again, in order to determine the relative predictive value of attitude/belief and agency/context variables to administrative formalization, significant predictor variables were submitted to a second multiple regression analysis. The results of this analysis are shown in the right hand columns of Table 31. This second analysis revealed that only the attitude and belief/perception variables remained as significant predictors of formalization. Thus, the sixth hypothesis, which predicted that attitudes/beliefs would be more predictive of formalization, was supported.

Summary of hypotheses tests. Table 32 presents a summary of the results of the hypotheses tests. In general, results indicated that variability in the two criteria was explained by different models of prediction. Utilizing first-order correlations, organization

Table 31: Predictors of administrative formalization. Results of stepwise multiple regression analyses.

	First Analyses		Second Analysis	
	β	R	β	R^2 Change
Attitude scales:				
Negative attitudes to FSS	.46			
Parent involvement in planning	.30			
Positive attitudes to FSS (tolerance too small for procedure)				
Belief/perception scales:				
Administrative support	.11			
Staff support	-.01			
Agency capacity	.33**		.30*	
Family/community support	.75**	.62	.52**	.29**
Agency/context characteristics:				
Agency budget	-.62			
Demand (subsidy enrollment)	.85*	.30	.09	.01
Avg. personal income	-.23			
Government spending per capita	.04			

* $p < .05$, ** $p < .01$

Table 32: Review of hypotheses results.

Hypothesis:	Configuration Criteria: Services	Configuration Criteria: Formalization
1: Organization size will be positively correlated with family support services (FSS) configurations.	Supported Table 26	Not supported
2: Service area population size, density, wealth and demand will be positively correlated with FSS configurations.	Supported Table 26	Not supported
3: Attitudes of stakeholders regarding FSS will be positively correlated with FSS configurations.	Supported Table 27	Not supported
4: Beliefs of stakeholders regarding factors which encourage or discourage the implementation of FSS will be positively correlated with family support configurations.	Supported Table 27	Supported Table 27
5: Organization status and level of decision-making participation of stakeholders will moderate the predictive value of stakeholder attitudes and beliefs to FSS configurations.	Not supported Table 29	Not supported Table 29
6: Beliefs and attitudes of stakeholders will be more predictive of FSS configurations than agency and service area characteristics.	Supported Table 30	Supported Table 31

and service area characteristics, and attitudes of stakeholders toward family support were predictive of variability in the number of services but not the degree of formalization. Only beliefs/perceptions regarding factors which inhibit or encourage family support, and behavioral intentions were predictive of both services and formalization criteria.

Although organizational and decision-making status of the stakeholders correlated with their attitudes, beliefs/perceptions, and behavioral intentions, the interaction between status and attitudes/beliefs/intentions did not moderate the predictive value of these variables to the criterion. A series of simultaneous entry regression analyses revealed that attitudes/beliefs of stakeholders were more predictive of both the services criterion and the formalization criterion.

Beyond the Hypotheses: Exploratory Path Model of Predictors

Research and theory regarding the adoption and implementation of innovative services have suggested that organization and context characteristics, as well as individual characteristics, are predictive of implementation. The hypotheses tested in this study so far support this general theory. As a further exploration of this theory, the path model which was described in chapter one was examined for each criteria using ordinary least squares path analysis (Hunter & Hamilton, 1992). This analysis was conducted as an exploration of the relevance of Lewin's (1951) field theory and Ajzen and Fishbein's (1980) theory of reasoned action to the implementation of family support services, thereby testing the mediating effect of behavioral intentions to the relationship between attitude/belief predictors and the criteria. In path analysis, when a mediating variable is entered as an explanatory variable, a non-significant path coefficient for the direct effect indicates that the variance is explained as hypothesized. However, a significant path coefficient after accounting for effects of mediating variables would indicate a direct effect that was not accounted for by the mediating variables.

In testing the path model, only those variables with significant correlations with the respective criterion variables (see Tables 26 and 27) were entered. Variables used in the

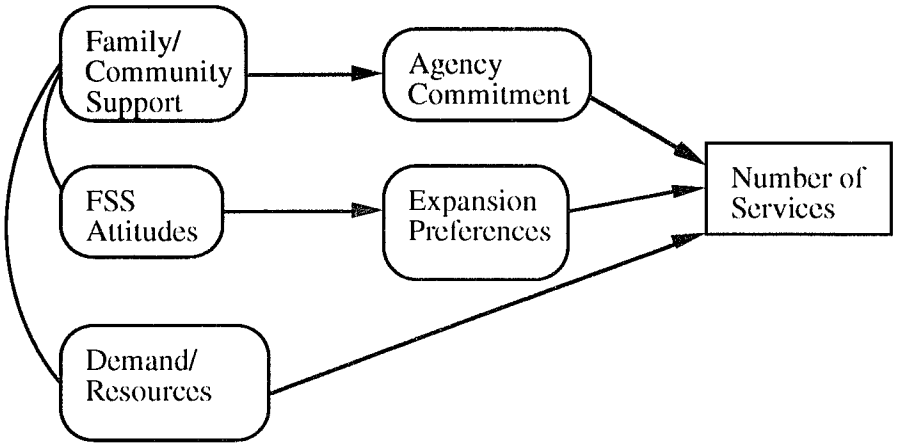

Figure 2
Hypothesized path model of predictors of number of different services

---

evaluation of the model also needed to be significantly correlated with antecedent and consequent path variables. Further, item and scale measures which were highly inter-correlated and similarly correlated with the criterion variable were combined into more general constructs, the variable with the strongest correlation with the criterion was used in the path analyses.

Path model of predictors of number of services. As shown in Figure 2, the number of services implemented was hypothesized to be a function of demand/resources, perceptions of family and community support for services, and attitudes toward family support. Previous correlational analyses indicated that both positive attitudes and negative attitudes toward family support (FSS) were significantly correlated with the criterion and were highly intercorrelated. In order to eliminate problems of multi-collinearity, positive attitudes toward family support, which had the strongest correlation with the criterion, was

entered in the path analysis. The relation of the criteria to family and community support was hypothesized to be mediated by the behavioral intention, agency commitment to hiring and training staff for family support. The relation of the criteria to family support attitudes was hypothesized to be mediated by preference for expansion and improvement of services. Further, as hypothesized/modeled, beliefs and attitudes were correlated.

In regard to demand for services and agency resources, as was shown in Table 26, demand, population, population density, and agency budget were highly inter-correlated. Thus, the four variables were modeled as a four part demand/resources construct. The assumption was that areas which have a larger population base create a higher demand for services which agencies then use to justify and argue for larger budgets. As demand for services was the strongest predictor of the number of services agencies implemented, it was used in the path analysis. The model also depicts the hypothesized correlation between demand and stakeholders' perceptions of family and community support for services.

Path coefficients are presented in Figure 3, along with respective 95% confidence interval estimates. As hypothesized, attitude toward family support was significantly correlated with perception of family and community support (corrected $r = .71, \pm.30$). Demand was also significantly correlated with perception of family and community support for services (corrected $r = .35, \pm.32$).

As hypothesized, the number of different services provided by agencies was explained by a pattern of relationships which included demand/resource characteristics, and attitudes and beliefs/perceptions of stakeholders mediated by behavioral intentions. When number of services was regressed onto agency commitment, expansion preferences, and demand/resources ($R = .67; \pm .20$), demand ($\beta = .42; \pm .24$) and agency commitment ($\beta = .43; \pm .28$) remained as significant predictors (i.e., the confidence interval did not include 0) of the number of services implemented, while expansion preferences approached significance ($\beta = .21; \pm .30$). Analysis of the model as a whole (χ^2 (df = 7) = 4.34; n.s.)

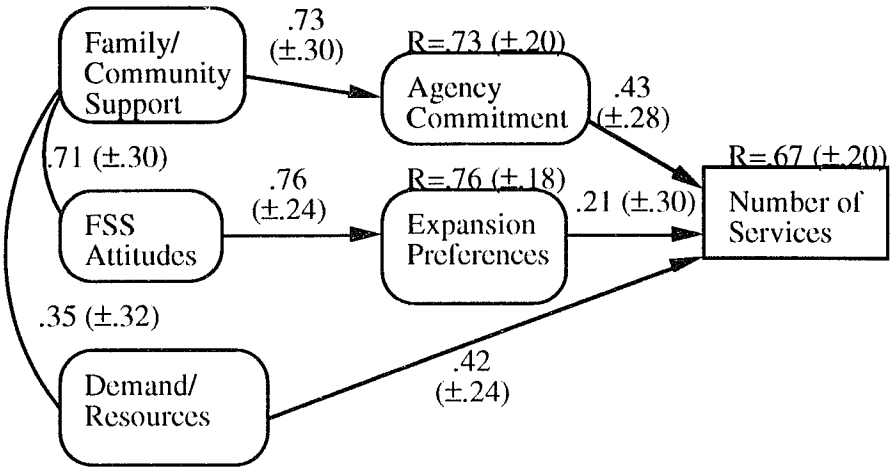

Figure 3
Examined path model of predictors of family support services

---

indicated that the hypothesized path adequately explained all of the direct effects of the exogenous variables (i.e., all departures could be explained by sampling error). Therefore, the hypothesis that behavioral intentions would mediate the effect of attitudes and beliefs/perceptions on the criteria was supported. The paths as modeled accounted for 42% of the variance (R = .65; ± .20).

Path model of predictors of formalization. Research regarding innovation implementation suggests that different models of prediction will be found for different types of configurations, such as an innovation in practice/technology or administration. For example, research by Kimberly and Evanisko (1981) found predictors of technological innovations to be different from predictors of administrative innovations. Also, hypotheses tested for this research suggest differing models of prediction for services implementation

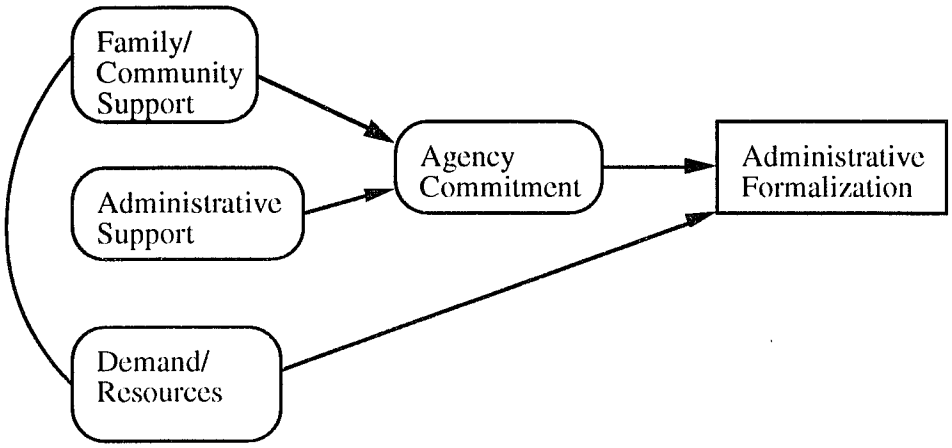

Figure 4

Hypothesized path model of predictors of administrative formalization

---

and administrative formalization. While variation in services was a function of both attitudes and beliefs/perceptions, variation in administrative formalization was primarily a function of beliefs/perceptions, since no attitude variables were significantly correlated with this criterion (see Table 27). Thus, the hypothesized model which was examined included only two primary paths: one associated with belief/perception variables, the other associated with agency/context characteristics.

As shown in the hypothesized path model in Figure 4, the predictive value of perceptions of family and community support and administrative support to the criterion was mediated by agency commitment (behavioral intention). Further, demand was modeled as a direct predictor of the criterion, and also as a correlate of perceptions of family and community support. However, given the results of zero-order correlational

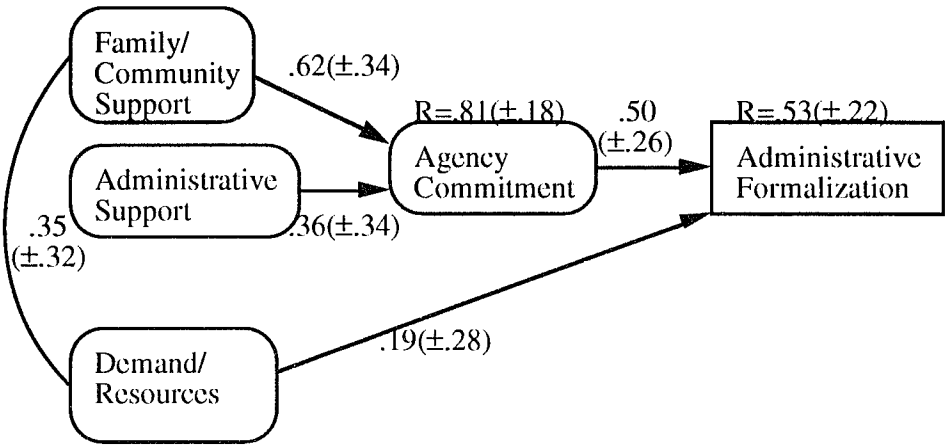

Figure 5
Examined path model of predictors of administrative formalization

---

analyses and the multiple regression tests of hypothesis 6 for this criterion (see Table 31), demand will most likely not remain as a significant predictor of administrative formalization.

As shown in Figure 5, the direct link of formalization on agency commitment (i.e., the behavioral intention) was significant (β = .50; ± .26). The links of agency commitment on perceptions of family and community support (β = .62; ± .34) and administrative support (β = .36; ± .34) were also significant and accounted for 66% of the variance (R = .81; ± .18). Demand/resources, as predicted, was significantly correlated with family and community support (corrected r = .35; ± .32), however, demand/resources was not significantly associated with formalization (β = .19, ± .28). Analysis of the model as a whole (χ^2 (df = 3) = 1.28; n.s.) indicated that the hypothesized path adequately explained all of the direct effects of the exogenous variables (i.e., all departures could be explained by

sampling error). Therefore, the hypothesis that behavioral intentions would mediate the effect of beliefs on the criteria was supported. The paths as modeled accounted for 28% of the variance ($R = .53; \pm.22$).

CHAPTER 4

Discussion

The purpose of this research was to improve upon three limitations in previous work on innovation implementation: the scarcity of studies examining the ecology of implementing innovative services, including the combined effects of individual, organizational, and contextual factors; the lack of research focusing on attitudes and beliefs/perceptions as individual predictors of implementation; and the limited statistical sophistication. This research was focused on family support services in order to better understand the factors which account for the wide diversity in implementation of this innovative practice initiative so that potential avenues for enabling further implementation may be determined. These issues were addressed in the context of testing the general hypothesis that implementation is determined by characteristics of the agency and its service area together with characteristics of individuals in the organization.

In general, the findings support previous research (Baldridge & Burnham, 1975; Castellani et al., 1986; Ireys et al., 1985; Kimberly & Evanisko, 1981; Rogers, 1983) and theory (Havelock, 1971; Rogers, 1983) which suggested that characteristics of the organization and its context are predictive of innovation implementation. For the number of different services implemented, relatively moderate correlations were found with agency and service area characteristics, specifically budget, demand, service population and density. These findings are similar to previous findings (Castellani et al., 1986; Ireys et al., 1985) which suggested that agencies with larger budgets and higher service area

population densities provided more services. Apparently, areas which have a larger population base create a higher demand for services. Agencies most likely utilize this perceived demand to justify increased budget requests, and then use the expanded resources to provide more diverse services. It is also possible, as discussed in the literature review, that larger agencies potentially have more capacity to shift resources to support the implementation of new services. Therefore, agencies with larger population bases, and larger budgets may be able to provide a greater diversity in services from existing resources rather than merely obtaining new resources to fund the services. Both of these explanations are possible within any given system. Yet, in recognition that the relationship between demand/resources and number of different services implemented was only moderate, in some cases perceived demand and funding may be used to expand a particular service instead of expanding the diversity of services offered. This explanation may help to understand why longitudinal research of Herman and Hazel (1991) failed to find a statistically significant relationship between increases in funding over time and the resultant diversity in services implementation. However, other explanations are possible.

As has been suggested by advocates of family support (Agosta, Bradley, Rugg et al., 1985; Knoll et al., 1990; Taylor, 1989), attitudes which are in harmony with the innovative practice, such as those favoring the innovative philosophy and encouraging of expansion, are important to the adoption and implementation of more diverse aspects of a 'loosely bundled' innovation such as family support. This research supports previous research (Backer et al., 1986; Fairweather et al., 1974; Hage & Dewar, 1973; Rogers, 1983) and theory (Agosta, Bradley, Rugg et al., 1985; Rogers, 1983; Sabatier & Mazmanian, 1981; Scheirer, 1981; Taylor, et al., 1989) which suggested that characteristics of individuals, their attitudes and beliefs/perceptions, would be predictive of innovation implementation. Relationships between attitude and belief/perception scales and the number of services implemented were moderate and sometimes stronger in comparison with relationships with demand/resources. In regard to attitudes, reasoned action theory (Ajzen & Fishbein, 1980)

suggested that attitudes toward family support philosophy and implementation would be predictive of behavior, i.e., implementation. Results supported this theory.

Reasoned action theory also suggested that perceptions of support from peers, administration, and the wider community, i.e., the subjective norm, would be predictive of behavior. This research also supported this aspect of the theory. Perceptions of greater family advocacy and community support for services were significantly related to more services being implemented. Further, beliefs regarding the subjective norm, such as perceptions of family, community, and administrative support were related to the implementation of more formal administrative structures.

In regard to the relative importance of agency, context and individual predictors, individual characteristics were more important than agency and service area characteristics for the prediction of services implementation. This finding is in contrast to previous research (Baldridge & Burnham, 1975; Kimberly & Evanisko, 1981) which found agency and context characteristics to be more important. The discrepancy can be accounted for by the fact that previous research focused on individual characteristics such as age, education, gender, etc., and failed to measure attitudes and beliefs/perceptions of organization personnel. Thus, individual characteristics were not found to be relevant. In general, results pertaining to both criteria support theoretical arguments (Agosta, Bradley, Rugg et al., 1985; Berman & McLaughlin, 1978; Browning et al., 1981; Glaser et al., 1983; Knoll et al., 1990; McLaughlin, 1987; Zaltman et al., 1973) and Hage & Dewar's (1973) findings that individual values/beliefs are more predictive of diversity in implementation than agency characteristics. Also contrary to previous research (Kimberly & Evanisko, 1981), factors related to organizational structure and context were not significant predictors of administrative changes. Instead, what seemed to be important in understanding implementation of administrative practices for family support services were factors associated with agency personnel, their perceptions of the need and community support for services, and perceptions of agency capacity for providing services.

As was indicated in the background literature review, previous research focused primarily on univariate analyses. Multivariate analyses, when utilized, were geared at defining the relative importance of agency and context characteristics. This approach, as this research has shown, limits our understanding by neglecting to account for the various multiple correlates of the criterion. In order to extend our understanding of innovation implementation beyond a discussion of relative importance of agency/context versus individual characteristics, path models were hypothesized and tested based on theoretical considerations. Theories which emphasize the role of people's perceptions of their environment and their attitudes toward the innovation (i.e., field theory and reasoned action theory) were used to formulate causal models for multiple predictors of the criteria.

Implementation was modeled as a function of agency/context forces, and individual attitudes and perceptions of the social norms for implementation which were mediated by their behavioral intentions to implement the innovation. As proposed, the number of different services implemented was predicted by attitudes toward family support, mediated by intentions to expand services. Diversity in services implementation was also predicted by perceptions of family and community support for services mediated by the behavioral intention to hire and train staff for family support. Further, structural characteristics of the agency and service area were also predictive of the number of services. Agencies with larger budgets, more populated service areas, and higher demand for services implemented more services. Since demand for services was correlated with perceptions of support from families and the community for services, and these perceptions were highly correlated with attitudes, it is difficult to separate out the relative importance of attitudes/beliefs and structural characteristics.

Consistent with field theory and reasoned action theory, individuals evaluate the pressures to implement or not implement family support services in forming their attitudes toward the innovation and behavioral intentions. These pressures include the actual demand for services and the agency's capacity to implement services, along with perceived

support from others for implementation. The important point is that beliefs/perceptions and attitudes are just as important as fiscal resources and demand to the prediction of services implementation. Demand and resources may be necessary, but are not sufficient to encourage diversity in family support services implementation.

The predictive value of individual characteristics, i.e., beliefs/perceptions, was even stronger in regard to administrative formalization of services. Formalization was best understood as primarily a function of beliefs/perceptions. In the path model, formalization was a function of stakeholders' perceptions of family and community support along with perceptions of administrative support mediated by agency commitment to hire and train staff for family support (i.e., the behavioral intention). No attitude or agency/context characteristics were found to be important to the prediction of formalization.

Thus, the findings support previous research (Kimberly & Evanisko, 1981) which suggested that the variability in the two criteria, number of services and administrative formalization, would be explained by different models of prediction. Results suggest that antecedent conditions for the implementation of formal administrative structures, and thus the routinization of the program, differ from conditions to implement more diverse services, in that formalization was not predicted by demand/resource explanations or attitudes toward family support philosophy and implementation. Perhaps, formalization/routinization is based on attitudinal resistance theories which suggest that people resist innovations that appear to require too much change or are perceived to devalue their knowledge and skills (Glaser et al., 1983; Legge, 1984). The formalization measure included practices that require new views of the role of the professional-parent relationship (parent advisory committees) and a restructuring of standard operating procedures (program structure for family support). Those whose support is required for such changes in administrative structures, i.e., the administration, expressed less favorable attitudes toward parent involvement in services planning. Stakeholders' perceptions of administrative support was an important predictor of the formalization criterion.

Yet, correlations between services and formalization suggest that as more family support services are implemented, more formal administrative procedures are also implemented. Perhaps, as more services are implemented, people in the organization may become familiar with family support and thereby more supportive of the innovation. As the subjective norm for the behavior becomes supportive, people may then be more inclined to explore possibilities of routinizing their efforts. Conversely, routinization may also facilitate implementation of more diverse services.

These considerations suggest that a better conceptualization of the role of attitudes, beliefs/perceptions and structural characteristics may be found in system dynamic models and the concept of feedback loops (cf. Levine, Van Sell & Rubin, 1992). In this case, attitudes and beliefs/perceptions not only affect services implementation, but services implementation may also change attitudes and beliefs/perceptions which then further impact services implementation and routinization. Also, as demand increases, perceptions of demand may increase, encouraging the implementation of services, which then fosters recruitment of clients, which then can increase demand for services as more families become aware of the services that are being provided. Longitudinal research which focuses on change over time may help in the determination of whether a system dynamic model, as compared to linear regression models, presents a better understanding of the process of innovation implementation and routinization.

Despite predictions suggested by conflict of interest theories that organizational status will moderate the predictive value of attitudes to implementation (Hasenfeld & Brock, 1991; Sabatier, 1987b; Scheirer, 1981), no significant attitude/belief by status interaction effects were found for either criteria. This finding suggests that for family support services, contrary to the 'top down' approach to implementation, attitudes and beliefs/perceptions of all those in decision making roles are important in determining performance. However, attitudes and beliefs/perceptions were correlated with role and decision making status. Staff expressed more positive attitudes toward family support

philosophy and implementation, and perceptions of lesser agency commitment, lesser family and community support for services, and lesser administrative support for services. Those more involved in decision making and of higher organizational status expressed less favorable attitudes toward expansion and improvement of services. This, in combination with staff's more positive attitudes toward family support philosophy, may help to explain why staff saw administration as less supportive of family support and their agency as less committed to implementing support services than administrators did. Staff may perceive a conflict between what administrators say they support, and administrators' behavioral intentions as identified by their greater hesitancy to expand and improve services.

Certain constraints on the generalizability of the findings should be noted. First, because family support services are widely accepted and implemented across Michigan's mental health services system, the findings may only be generalizable to other similar service systems and to points in time beyond the initial stages of policy and services implementation. Initial implementation may be more or less dependent on individual characteristics. For example, the conflict of interests model, which suggests that organizational status will moderate the predictive value of attitudes to implementation, may be more important to understanding initial stages of implementation. Once an innovative service or policy has been widely accepted and routinized, there may be more similarity in attitudes of staff and administration, thus the conflicts of interests model may no longer be operative. Once again, longitudinal assessments may be necessary to address this issue. Specifically, do attitudes and beliefs change over time, and if so, are these changes reflected in changes in implementation behavior? Also, does the relative importance of individual, organizational and context characteristics change over time, and if so, how? At what point in time, if any, is the conflict of interests model important to understanding implementation behavior?

The widespread implementation of family support services in Michigan may also have produced a situation where agency personnel attitudes and beliefs/perceptions, in general,

were positive towards the implementation of family support services. Results of the scale development analyses suggested that attitudes were skewed toward the supportive end of the scale. Many recognized the need for family support and would like to see services expanded or improved. Participants in this study also perceived a general sense of support from administration, staff and the community for the implementation of family support services. Although they identified several barriers to implementing services, including lack of resources within the agency and the surrounding community, and capacity to provide services, they also identified several factors which have enhanced their agency's ability to provide services. These factors included support from agency personnel, state level funding allocations, training opportunities and hiring of staff with relevant expertise.

The skewed results of the attitude measures suggested people may have responded to item wording and content in a 'politically correct' manner. In the months just prior to and during the time this research was being conducted, advocacy efforts both by parent groups and state level administration to improve the availability and accessibility of family support services may have generated a sense that attitudes disfavoring family support were not acceptable. The skewed results of the attitude measures may have limited this research's ability to adequately determine the relative predictive value of attitudes on the criteria.

A further difficulty related to the scale development analyses was the common content of the items which were deleted. First, an often discussed theme in the family support literature is the importance of recognizing the value of family oriented services over individual oriented services. Family support advocates argue that deinstitutionalization and the resultant focus on providing individuals with support services has created a barrier to the implementation of family support services (Agosta, Bradley, Rugg et al., 1985; Herman et al., 1992; Moroney, 1979). They argue that although a focus on supporting natural networks, such as the family, will ultimately better serve the individual, many service agencies continue to focus on the individual as the service recipient rather than the family. Several attitude and belief items were written to tap into this philosophy. Most of

these items were deleted during the analyses. Comments from participants suggest that the argument of individual versus family based services may be too simplistic, that both are necessary and, therefore, important. For example, individualized services may be best for adults with developmental disabilities, while family oriented services may be best for children. Participants who were drawn from either child or adult oriented services may hold differing viewpoints. Since age based distinctions were not made in the items pertaining to this debate, answers may have been unstable, resulting in low internal reliability and inter-item commonality.

A second theme among the items deleted from the scales was related to change. Literature on innovation implementation suggested that attitudes toward change would be related to behavior (Legge, 1984). Items which attempted to measure this construct were also deleted during the scale development analyses. Comments from participants suggest that the items may have been confusing or unclear, resulting in unreliable responses. Another explanation may be that, once again, given the widespread implementation of family support services, attitudes reflecting a resistance to change may no longer be consistently evident, thereby resulting in low inter-item commonality. Other than these two exceptions, results of the scale development analyses were consistent with expected domains of measurement. Resultant scales measured attitudes toward family support philosophy and implementation, perceptions of the external and internal subjective norm for implementation, and behavioral intentions to expand and improve services.

In regard to the criteria, a wide diversity of implementation was found within the configurations studied. Apparently the "loose bundling" of family support has allowed for this diversity in implementation, with some agencies providing several different services and routinizing their efforts with the adoption of several administrative components, while others have implemented very few services and no administrative components. This observed variety in implementation and factors which potentially explain the variations were the focus of this research. However, a limitation on the generalizability of the

findings related to the services criterion measure should be noted. Respondents' definitions of what constitutes family support varied, with several services identified as family support that had not been formally recognized by state policy or in the literature. It appears that although family support is gaining acceptance, people may still be unclear as to what "family support" means. Perceptions of respondents support this finding; 41% indicated that people at their agency lacked a clear understanding of what family support services are. Clearly, advocacy and policy efforts to clarify what is meant by family support services are still needed and should be encouraged.

Overall, the results of this research suggest that Lewin's field theory and Ajzen and Fishbein's theory of reasoned action can guide our understanding of innovation implementation in public mental health settings, as well as the implementation of family support services in other states. In regard to 'loosely bundled' mental health services innovations, such as family support, context demand forces and availability of sufficient resources may be necessary for implementation, but not sufficient. Organizations may have the resources, the demand may be evident in the service area, but without the support from agency personnel, as evident by their attitudes and beliefs/perceptions, few if any components of the innovation will be implemented. Conversely, attitudes and belief/perceptions may support services implementation, but if the resources are not available, nor the demand evident to justify implementation, agencies are not likely to implement more diverse services.

Further, it is important to recognize that antecedent conditions for routinization (Yin, 1981) will differ from conditions for initial implementation. As suggested by this research, formalization/routinization, which appears to be correlated with an increase in the number of innovation components implemented, is more a function of perceptions of agency personnel of the need and community support for the innovation along with administrative commitment, than of actual demand characteristics of the service area. Therefore, in public mental health service areas, the stability and continued implementation of innovative

policies and procedures will be dependent upon support from agency personnel, especially administrative support, and their perceptions of community support. In other words, widespread community recognition and advocacy for the implementation of an innovative mental health service philosophy, such as family support, will spur mental health agencies to move towards full implementation and routinization of the innovative practice.

Both of the path models predicting number of services and formalization point to the importance of family advocacy and community support for services, mediated by agency commitment to implementing family support. Several policy and advocacy implications can be suggested based on these findings. First, as more families inquire about and enroll in the family support subsidy, perceptions regarding the demand for family support will change, potentially leading to further implementation and routinization of family support services to match the perceived demand. Also, efforts to directly affect these perceptions, such as advocacy campaigns directed at agency personnel to heighten their awareness of the need for services and families' desire to receive services, can also help to spur the implementation and routinization of family support services. Second, perceptions of community agency referrals for services and the availability of sufficient community resources were included in the measurement of family and community support for services. Therefore, policies and practices which encourage collaboration and coordination of services among community agencies that serve people with developmental disabilities and their families may help to spur implementation and routinization by impacting the agency personnel's perception of community support for services. Services coordination efforts may also increase the visibility of services provided by mental health agencies which then could increase referrals, thus potentially affecting perceptions of demand for services.

Finally, it is clear from the literature and this research that attitudes toward family support and attitudes regarding parental involvement in services planning (which were highly correlated, $r = .93$, with attitudes toward family support) are important to the implementation of family support services. Policy and advocacy efforts which are geared

toward encouraging parents to get involved, and also encouraging service providers to work with parents as co-planners should be promoted. Programs should encourage families' active participation in planning the service system, empowering them to design and select the services they receive. In Michigan, family support services policy requires that agencies utilize parent advisory committees in services planning. However, this policy has not been widely implemented. Efforts by the state to enforce this policy should be directed at administration, since their attitudes were found to be less favorable toward parent involvement. These efforts would not only benefit parents by encouraging their involvement, but may also help to increase the number of family support services components being implemented across the state. Michigan's family support services' evolution began with parent advocacy, the continued success can also rely on parental advocacy and involvement. Efforts to encourage parent groups to advocate for their rights and involvement in services planning locally, can have a ripple effect, increasing positive attitudes toward family support and parental involvement and thereby, increasing efforts to meet perceived demands by further developing and enriching current efforts to implement family support services.

APPENDIX A

Stakeholder Survey and Accompanying Letters

APPENDIX A

Stakeholder Survey and Accompanying Letters

Community Mental Health Professionals' Opinion Survey Regarding Family Support Services

Kelly L. Hazel, Principal Investigator
Department of Psychology
Psychology Research Building
Michigan State University
East Lansing, MI 48824-1117

This research is supported in part by the Michigan Department of Mental Health and the Michigan Developmental Disabilities Council

2

Instructions and Clarifications

* This survey concerns issues surrounding support services provided to families who are caring at home for a member who has a developmental disability. These services are often referred to as "**family support services**", and may include:

respite care (in- or out-of home care, and the family friend model)
family services coordination (family centered case management services)
parent, family, or sibling support groups
family counseling
behavioral management training
parenting skills training and other parent education activities
family support oriented newsletters
parent-to-parent networking
special in-home services (nursing, special therapies, behavioral trainer, etc.)
home renovations and adaptive equipment
summer or after school recreation programs
family support subsidy and other forms of financial assistance
other services or activities provided to families unique to your board/agency

Your board/agency may provide a full range of "family support services", a few select services (such as respite care and family services coordination), or none at all. Whatever the case may be for your board/agency, we are interested in what you have to say.

* All questions should be answered based on **your own** opinions and knowledge. Please do not give this survey to someone else to answer. You were selected to answer this survey based on your position with your local community mental health center or contracted agency. Because we want opinions from a variety of community mental health professionals, including administrators, board committee members, and direct services staff, your answers are important. Your personal response will ensure representativeness.

* We use the term **board/agency** to indicate activities of the local community mental health center and it's contracted agencies. You may be an employee or volunteer of the center or a contracted agency. Whichever the case, references to activities provided by your board/agency include both directly operated programs of the center and programs provided through contract agencies. If you are an employee of a contracted agency of a community mental health center, please give one answer to each question which best reflects your opinions regarding both your agency and your community mental health center.

* Please answer all questions as best as you can. Do not skip questions unless directed to do so. For questions in which a range of answers is provided, unless otherwise indicated, please circle only one answer to each question.

* Do not write your name on the survey.

* After you have completed the survey, please return it using the addressed return envelope provided to:

Kelly L. Hazel, M.A.
Department of Psychology
Michigan State University
East Lansing, MI 48824-1117

If you have any questions or need clarification, please call Kelly L. Hazel at (517)394-6428, or leave a message at the Psychology Department at Michigan State University, (517)355-9561, and she will return your call as soon as possible.

Thank-you for your cooperation

1. Before we get to your opinions, we would like you to think about the services your board/agency (i.e., the community mental health center and its contracted agencies) provides. In your view, what services and activities does your board/agency currently provide to support families who are caring at home for their member(s) who have a developmental disability?

_____

_____

_____

_____

_____

_____

_____

_____

2. The following items are designed to determine what community mental health service professionals, such as yourself, feel about support services for families caring at home for their member(s) with a developmental disability, commonly referred to as "family support services". Please respond to the items in terms of your own perceptions, or how you feel about your board/agency's implementation of support services for families. Circle the response that most closely indicates how you feel about each statement.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I feel that programs and services for people with disabilities should take priority over support services for families.	SD	D	N	A	SA
I would like to see my board/agency expand or improve its family support services.	SD	D	N	A	SA
Since most families with children with disabilities are supported by the school system, it is not necessary for mental health to also provide services for them.	SD	D	N	A	SA
I am personally committed to the development and/or expansion of family support services at my board/agency.	SD	D	N	A	SA
Family support services require too much change in the way my board/agency provides services to our clients.	SD	D	N	A	SA

4

What do you think?	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Parents are very knowledgeable and competent resources and should be involved in all services planning for their family member who has a developmental disability.	SD	D	N	A	SA
There are needs in our community that are much more pressing which should be addressed first, before we develop family support services any further.	SD	D	N	A	SA
Family support services take up too much staff time that would be better devoted to other, more needed services.	SD	D	N	A	SA
I think that family support should be a greater percentage of my board's overall budget.	SD	D	N	A	SA
I feel that the focus of services should be on the person with disabilities, not the family.	SD	D	N	A	SA
I would like to encourage and help other service providers implement or improve family support services.	SD	D	N	A	SA
I would like to see my board/agency discontinue providing family support services.	SD	D	N	A	SA
I personally do not see a strong enough need in our community to warrant any further development of family support services at our board/agency.	SD	D	N	A	SA
I feel that all support services to people with a developmental disability who are living at home are more effective when they are family centered and family driven.	SD	D	N	A	SA
I think that my board/agency should redirect current resources to provide more support services for families.	SD	D	N	A	SA
Too many families are not capable of functioning as care givers for their family member who has a developmental disability.	SD	D	N	A	SA
I feel that supporting families should be a top priority at my board/agency.	SD	D	N	A	SA

What do you think?	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Many activities and services related to family support are not within the domain of mental health responsibility, other service providers should be providing these supports.	SD	D	N	A	SA
I feel that parents' views and opinions regarding needed services and service delivery practices are very important to overall services planning.	SD	D	N	A	SA
I am not at all convinced that family support services are an effective or appropriate way of helping people with disabilities.	SD	D	N	A	SA
I personally do not think there is a need for family support services.	SD	D	N	A	SA
I think that my board/agency should find out more about family support services before we go any further.	SD	D	N	A	SA
Families have a lot of resources for help and support from other service providers, mental health should not be spending its scarce resources too.	SD	D	N	A	SA
I think parents should be actively involved in planning overall services for people with developmental disabilities.	SD	D	N	A	SA
I feel that family support concepts and practices should be incorporated into the overall way of providing services to individuals with disabilities and their families. Family support should be my board/agency's way of doing business.	SD	D	N	A	SA
I would like to know what other boards/agencies are doing in regards to family support services.	SD	D	N	A	SA
I think that staff resources should be redirected to put more emphasis on supporting families	SD	D	N	A	SA

6

3. We are interested in your opinion about how people at your board/agency feel about mental health service agencies providing support services for families. What do you think people at the following levels in your board/agency's administrative structure feel? Based on your experience, are they neutral or do they highly object to, somewhat object to, somewhat approve of or highly approve of mental health agencies providing family support services? Circle your response. If the description of an individual or group is not relevant to you, please indicate so by putting a NA next to the description.

In regards to family support services, how do the following feel:	Highly Object	Somewhat Object	Neutral	Somewhat Approve	Highly Approve
The staff you supervise?	HO	SO	N	SA	HA
Your professional peers?	HO	SO	N	SA	HA
Your immediate supervisor?	HO	SO	N	SA	HA
Your board's chairperson?	HO	SO	N	SA	HA
Other board committee members?	HO	SO	N	SA	HA
The board's executive director?	HO	SO	N	SA	HA
Your board/agency's top administration?	HO	SO	N	SA	HA
Your board/agency's developmental disabilities services administration?	HO	SO	N	SA	HA
Your board/agency's developmental disabilities services staff?	HO	SO	N	SA	HA
Your board/agency's family support services staff?	HO	SO	N	SA	HA
Yourself?	HO	SO	N	SA	HA

4. There is a wide variation across the state in the extent to which boards/agencies are providing support services for families. We are interested in determining what community mental health professionals are concerned about in regards to providing family support services. Please respond to the items in terms of <u>your own perceptions</u>, or how you feel about the issues. Circle the response that most closely indicates your opinion to each statement.

	Very Untrue	Somewhat Untrue	Neither	Somewhat True	Very True
My board/agency has sufficient capacity to provide adequate support services to all families in our community who need/want them.	VU	SU	N	ST	VT
In general, people at my board/agency are not interested in providing services for families.	VU	SU	N	ST	VT

What do you think?	Very Untrue	Somewhat Untrue	Neither	Somewhat True	Very True
My board/agency lacks sufficient staff resources to provide adequate family support services.	VU	SU	N	ST	VT
Providing support services for families is a top budget priority at my board/agency.	VU	SU	N	ST	VT
State Department funding allocations have helped my board/agency's ability to provide family support services.	VU	SU	N	ST	VT
My board/agency has provided the necessary opportunities for staff to improve their knowledge and learn the skills required to provide support services to families.	VU	SU	N	ST	VT
There is a sufficient number of qualified service providers (e.g. for respite care, in-home nursing, in-home behavioral management training, etc.) in our community to support my board/agency's efforts to provide family support services.	VU	SU	N	ST	VT
Families in our community have been very active in advocating for the development and/or expansion of family support services at my board/agency.	VU	SU	N	ST	VT
In general, people at my board/agency lack a clear understanding of what family support services are.	VU	SU	N	ST	VT
My board/agency has lacked the funding capacity to develop family support services.	VU	SU	N	ST	VT
My board has hired people who have the expertise needed to provide support services to families.	VU	SU	N	ST	VT
The various agencies and professionals who work with families in our community readily refer families to my board/agency for the services we provide.	VU	SU	N	ST	VT
Our mental health board committee members are committed to the development and/or expansion of family support services.	VU	SU	N	ST	VT

8

What do you think?	Very Untrue	Somewhat Untrue	Neither	Somewhat True	Very True
My board/agency has not been able to keep up with the demand for family support services, families have had to wait to get into the program or to receive services.	VU	SU	N	ST	VT
Families have been reluctant to take advantage of the services available at my board/agency.	VU	SU	N	ST	VT
My board/agency's administration is committed to the development and/or expansion of family support services.	VU	SU	N	ST	VT
There is a general lack of community interest and involvement in supporting individuals with disabilities and their families.	VU	SU	N	ST	VT
The system does not recognize the family as the client, only the individual with disabilities, which hinders our efforts to implement support services for families.	VU	SU	N	ST	VT
Families in our community really don't want family support servic s.	VU	SU	N	ST	VT
The attitudes and practices of most service providers in our community are that support services should be provided only to the individual with disabilities, they do not involve or support the family.	VU	SU	N	ST	VT

5. What plans (if any) does your board/agency have in regards to family support services in the near future?

_____

_____

_____

_____

_____

_____

_____

_____

So that we can compare and contrast your answers with other community mental health professionals, we would like to know some information about yourself and your role in the decision making processes at your board/agency.

6. What impact do you, personally, have on decisions regarding the overall planning and implementation of services at your board/agency? Circle your answer.

Very Little **Little** **Some** **Much** **Very Much**

7. How frequently do you participate in decisions regarding the overall planning and implementation of services at your aboard/agency? Circle your answer.

Never **Seldom** **Sometimes** **Often** **Always**

8. How frequently do you participate in decisions regarding the implementation and provision of services for individuals with developmental disabilities and/or their families? Circle your answer.

Never **Seldom** **Sometimes** **Often** **Always**

9. What impact do you, personally, have on decisions regarding services and supports to individuals with disabilities and/or their families at your board/agency? Circle your answer.

Very Little **Little** **Some** **Much** **Very Much**

10. How long have you worked or volunteered for this board/agency? Circle one answer.

A less than one year
B 1-2 years
C 3-5 years
D 6-10 years
E more than 10 years

11. What is your current position at this board/agency? Circle the one answer which best describes your current position.

A family support services staff
B developmental disabilities services staff (not family support)
C family support services/program administration
D developmental disabilities services/program administration
E service program staff for both MI and DD client services
F service program administration for both MI and DD client services
G contract service agency administration
H community mental health agency administration (e.g. director, asst. director)
I board committee member
J board committee chairperson
K other (please specify)_____

10

12. How long have you been in your current position at this board/agency? Circle your answer.

- **A** less than one year
- **B** 1-2 years
- **C** 3-5 years
- **D** 6-10 years
- **E** more than 10 years

→ **12a.** If less than one year in your current position, what position did you have prior to your current one?

_____

_____

13. Do you, personally, have a caseload of clients/families for which you are responsible? Circle your answer.

NO

YES

→ **13a.** If yes, what is the percentage of your caseload that has a developmental disability (as compared to a mental illness diagnosis)?

_____% has a developmental disability

13b. What are the age ranges of the persons who have a developmental disability? Please indicate the percentage of your caseload between the following ages.

_____% 0 and 18 years of age

_____% 19 and 26 years of age

_____% older than 26 years of age

=100 % of caseload with a developmental disability

14. Do any of your immediate family members (i.e., brother, sister, daughter, son, parent, spouse) have a developmental disability? Circle your answer.

NO

YES

If you have anything else that you would like to share with us, please write your comments on the back page of this survey.

Thank-you for your time and thoughts

MICHIGAN STATE UNIVERSITY

DEPARTMENT OF PSYCHOLOGY
PSYCHOLOGY RESEARCH BUILDING

EAST LANSING • MICHIGAN • 48824-1117

March 13, 1992

Dear Community Mental Health Professional,

The future direction of community mental health services for individuals with developmental disabilities has been a major focus of debate among policy makers, service professionals, individuals and their families. Much of this debate has been focused on services provided to support families caring at home for their member(s) who has a developmental disability, commonly referred to as "family support". In Michigan, family support services began in the early 1980s as pilot demonstrations and have subsequently been incorporated into ongoing services delivery at several boards. As a community mental health services professional, your opinions about this trend and about family support services in general are important to future mental health services planning.

You are one of a select few individuals who are being asked to give their opinions about support services for families. You were selected to answer this survey based on your position with your local community mental health center or its contracted agency. Because we are interested in the opinions of a variety of community mental health professionals, including administrators, board committee members, and direct services staff, your answers are important.

Your participation in this survey is voluntary. However, in order to ensure that the results will truly represent the thinking of mental health professionals at differing administrative levels across the state, it is important that every survey be completed and returned by the person to whom the survey was sent. The survey should only take you 15-25 minutes to complete. The time you spend now will greatly benefit mental health services recipients, service professionals, and the community in general. The results of this research will be made available to mental health services policy makers, service professionals, and other interested citizens.

You may be assured of complete confidentiality. The survey has an identification number for mailing purposes only. This is so we may check your name off of the mailing list when your survey is returned. Your name will never be placed on the survey. All research results will be presented in aggregate form, individual answers will not be identified. The return of an answered survey will indicate your consent to participate in this project.

If you have any questions or need clarification, please contact Kelly Hazel at (517)394-6428, or leave a message at the Psychology Department at Michigan State University, (517)355-9561, and she will return your call as soon as possible.

Thank-you for your assistance.

Sincerely,

Kelly L. Hazel, M.A.
Principal Investigator

STATE OF MICHIGAN

JOHN ENGLER, Governor

DEPARTMENT OF MENTAL HEALTH

LEWIS CASS BUILDING
LANSING, MICHIGAN 48913
JAMES K. HAVEMAN, JR
Director

March 2, 1992

TO: Community Mental Health Services Professionals

FROM: William L. McShane

SUBJECT: Opinion Survey Regarding Family Support Services

Michigan State University, in cooperation with the Services Research Unit of the Department of Mental Health, is conducting a study of the opinions of community mental health professionals. The purpose of the study is to determine professionals' views regarding services for families with members who have developmental disabilities, commonly referred to as "family support services". Kelly Hazel, who is undertaking this study as part of the requirements for the completion of her doctoral dissertation, is the principal investigator. Dr. Sandra E. Herman of the Services Research Unit will be overseeing the Department's role in the study.

Your participation in this project is strictly voluntary. However, since your answers are important to future planning, I encourage you to complete the enclosed survey as soon as possible. Your answers will help to ensure that the results of this study are representative of community mental health professionals' opinions. You can be assured that your answers will be confidential. If you have any questions about the survey, please contact Ms. Hazel at Michigan State University (517) 355-9561, or Dr. Herman at the Department of Mental Health (517) 373-3862.

SEH/cmc

MICHIGAN STATE UNIVERSITY

DEPARTMENT OF PSYCHOLOGY
PSYCHOLOGY RESEARCH BUILDING

EAST LANSING • MICHIGAN • 48824-1117

March 20, 1992

Dear Community Mental Health Professional,

About one week ago a survey was sent to you, seeking your opinion about family support services. If you have already completed and returned the survey to me, please accept my sincere thanks. If not, please do so today. Because it has been sent to only a select few, but representative, number of community mental health professionals, it is extremely important that you also be included in the study if the results are to accurately represent the opinions of community mental health professionals in Michigan.

If for some reason you did not receive the survey, or it has been misplaced, please call me right now (517-349-6428 or 517-355-9561) and I will get another one in the mail to you right away.

Sincerely,

Kelly L. Hazel, M.A.
Principal Investigator

MICHIGAN STATE UNIVERSITY

DEPARTMENT OF PSYCHOLOGY
PSYCHOLOGY RESEARCH BUILDING

EAST LANSING • MICHIGAN • 48824-1117

March 27, 1992

Dear Community Mental Health Professional,

About three weeks ago I wrote to you seeking your opinion on family support services. As of today I have not yet received your completed survey.

I have undertaken this study because of the belief that opinions of community mental health professionals such as yourself, should be taken into account in the formation of future policies regarding services for people with developmental disabilities and their families.

I am writing to you again because of the importance each survey has to the usefulness of this study. You were selected to participate based on your position with your local community mental health board or its contracted agency. Only a few professionals at each administrative level at each board or contract agency have been being asked to give their opinions about family support services. In order for the results of this study to truly represent the opinions of community mental health professionals such as yourself, it is essential that each person selected return their survey. So that the reporting of the results of this survey be timely, we need to receive all surveys by April 10, 1992.

If for some reason you did not receive the survey, or it has been misplaced, please call me now (517-394-6428 or 517-355-9561) and I will get another one in the mail to you today.

Thank-you for your assistance.

Sincerely,

Kelly L. Hazel, M.A.
Principal Investigator

MICHIGAN STATE UNIVERSITY

DEPARTMENT OF PSYCHOLOGY
PSYCHOLOGY RESEARCH BUILDING

EAST LANSING • MICHIGAN • 48824-1117

April 10, 1992

Dear Community Mental Health Professional,

About five weeks ago, I wrote to you asking you to respond to the "Community Mental Health Professionals' Opinion Survey Regarding Family Support Services". As of today I have not yet received your completed survey.

I am writing to you again because of the importance each survey has to the usefulness of this study. You were selected to participate based on your position with your local community mental health center or its contracted agency. Only a few professionals at each administrative level at each center or contract agency have been asked to give their opinions about family support services. This is a personal opinion survey. Only those to whom the survey was addressed should answer it. Please, do not pass it on to another person to answer. In order for the results of this study to truly represent the opinions of community mental health professionals such as yourself, it is essential that each person selected return their survey. At this time, we would greatly appreciate receiving your completed survey no later than April 24, 1992.

The survey should only take you 15-25 minutes to complete. The time you spend now will greatly benefit mental health services recipients, service professionals, and the community in general. The results of this research will be made available to mental health services policy makers, service professionals, and other interested citizens.

In the event that your survey has been misplaced, a replacement is enclosed.

Thank-you for your assistance.

Sincerely,

Kelly L. Hazel, M.A.

APPENDIX B

UCRIHS Approval Letter

APPENDIX B

UCRIHS Approval Letter

MICHIGAN STATE UNIVERSITY

OFFICE OF VICE PRESIDENT FOR RESEARCH
AND DEAN OF THE GRADUATE SCHOOL

EAST LANSING • MICHIGAN • 48824-1046

February 14, 1992

Kelly L. Hazel
Psychology Department
135 Snyder Hall

RE: CONFIGURATIONS OF FAMILY SUPPORT SERVICES IN MICHIGAN: ORGANIZATION STRUCTURE, CONTEXT AND ATTITUDINAL INFLUENCES, IRB #92-052

Dear Ms. Hazel:

The above project is exempt from full UCRIHS review. The proposed research protocol has been reviewed by another committee member. The rights and welfare of human subjects appear to be protected and you have approval to conduct the research.

You are reminded that UCRIHS approval is valid for one calendar year. If you plan to continue this project beyond one year, please make provisions for obtaining appropriate UCRIHS approval one month prior to February 14, 1993.

Any changes in procedures involving human subjects must be reviewed by UCRIHS prior to initiation of the change. UCRIHS must also be notifed promptly of any problems (unexpected side effects, complaints, etc.) involving human subjects during the course of the work.

Thank you for bringing this project to my attention. If I can be of any future help, please do not hesitate to let me know.

Sincerely,

David E. Wright, Ph.D., Chair
University Committee on Research Involving
Human Subjects (UCRIHS)

DEW/deo

cc: Dr. Frank Floyd

MSU is an Affirmative Action/Equal Opportunity Institution

APPENDIX C

Preliminary Analyses Results Tables

APPENDIX C

Preliminary Analyses Results Tables

Table C-1: Services identified as supportive of families of people with developmental disabilities.

	Participants
Family Support Services	% (*N*=339)
Respite Care (in general)	81
In-home Respite Care	17
Out-of-home Respite Care	20
Family Friend Respite	15
Case Management	68
Advocacy	11
Information and Referral	13
Support Groups (in general)	11
Family Support Groups	3
Parent Support Groups	9
Sibling Support Groups	5
Counseling or Therapy (in general)	22
Family Counseling	30
Individual Counseling	8
Behavior Management Training or Consultation	30
In-home Behavioral Training or Program Aid	4
Parent Education/Skills Training	20
Parent to Parent Network	9
Family Support Newsletter	8
In-home Services (in general)	19
In-home Nursing	7
Special Therapies	4
Adaptive Equipment	16
Home Renovations	9
After School or Latch Key Program	3
Recreation or Family Activity Program	8
Summer Recreation Program	6

Table C-1 (cont'd).

	Participants
Family Support Services	% (*N*=339)
Campership	7
Model Waiver 2 Program	25
Subsidy	54
Financial Assistance	4
Emergency or Crisis Services	3
Parent Advisory Committee	4
Other Services and Supports	
Permanency Planning	4
Guardianship or Adoption Planning	3
Psychological or Psychiatric Consultation	9
Assessments	6
Medical or Health Related Consultation	3
Foster Care	5
Day Activity or Partial Day Program	12
Work Activity or Supported Employment Program	8
Residential Services	5
Client Education Program (e.g., sexuality, life skills, etc.)	2
Outpatient or Life Consultation Program	4
Transportation	3

Table C-2: Descriptive statistics of attitude items.

What do you think?	Mean(SD)	Strongly Disagree 1 %	Disagree 2 %	Neutral 3 %	Agree 4 %	Strongly Agree 5 %
I feel that programs and services for people with disabilities should take priority over support services for families.	2.54(.91)	8	49	26	16	2
I would like to see my board/agency expand or improve its family support services.	4.29(.67)	1	1	7	52	40
Since most families with children with disabilities are supported by the school system, it is not necessary for mental health to also provide services for them.	1.75(.84)	41	49	4	4	2
I am personally committed to the development and/or expansion of family support services at my board/agency.	4.11(85)	2	2	14	47	35
Family support services require too much change in the way my board/ agency provides services to our clients.	1.96(.81)	27	57	11	4	1
Parents are very knowledgeable and competent resources and should be involved in all services planning for their family member who has a developmental disability.	4.27(.86)	2	2	7	44	45

Table C-2 (cont'd).

What do you think?	Mean(SD)	Strongly Disagree 1 %	Disagree 2 %	Neutral 3 %	Agree 4 %	Strongly Agree 5 %
There are needs in our community that are much more pressing which should be addressed first, before we develop family support services any further.	2.36(.89)	13	54	20	13	1
I feel that all support services to people with a developmental disability who are living at home are more effective when they are family centered and family driven.	4.19(.89)	1	6	9	42	42
Family support services take up too much staff time that would be better devoted to other, more needed services.	1.77(.66)	33	60	5	2	0
I think that family support should be a greater percentage of my board's overall budget.	3.67(.88)	0	9	31	43	17
I feel that the focus of services should be on the person with disabilities, not the family.	2.21(.88)	17	57	14	11	1
I would like to encourage and help other service providers implement or improve family support services.	3.94(.70)	1	2	16	64	17
I would like to see my board/agency discontinue providing family support services.	1.36(.69)	72	25	2	1	1

Table C-2 (cont'd).

What do you think?	Mean (SD)	Strongly Disagree 1 %	Disagree 2 %	Neutral 3 %	Agree 4 %	Strongly Agree 5 %
I personally do not see a strong enough need in our community to warrant any further development of family support services at our board/agency.	1.58(.70)	52	41	5	2	0
I think that my board/agency should redirect current resources to provide more support services for families.	3.48(.97)	2	15	32	37	14
Too many families are not capable of functioning as care givers for their family member who has a developmental disability.	2.30(.97)	19	49	19	12	2
I feel that supporting families should be a top priority at my board/agency.	3.87(.89)	1	6	21	47	24
Many activities and services related to family support are not within the domain of mental health responsibility, other service providers should be providing these supports.	2.72(1.12)	12	38	20	24	5
I feel that parents' views and opinions regarding needed services and service delivery practices are very important to overall services planning.	4.48(.53)	0	0	2	49	49

Table C-2 (cont'd).

What do you think?	Mean(SD)	Strongly Disagree 1 %	Disagree 2 %	Neutral 3 %	Agree 4 %	Strongly Agree 5 %
I am not at all convinced that family support services are an effective or appropriate way of helping people with disabilities.	1.60(.61)	46	50	4	1	0
I personally do not think there is a need for family support services.	1.37(.56)	66	32	1	1	0
Families have a lot of resources for help and support from other service providers, mental health should not be spending its scarce resources too.	1.77(.68)	35	55	7	2	0
I think parents should be actively involved in planning overall services for people with developmental disabilities.	4.38(.67)	0	1	5	47	46
I feel that family support concepts and practices should be incorporated into the overall way of providing services to individuals with disabilities and their families. Family support should be my board/agency's way of doing business.	4.04(.80)	0	4	18	49	30
I would like to know what other boards/ agencies are doing in regards to family support services.	4.15(.66)	0	1	11	59	29

Table C-2 (cont'd).

What do you think?	Mean(SD)	Strongly Disagree 1 %	Disagree 2 %	Neutral 3 %	Agree 4 %	Strongly Agree 5 %
I think that staff resources should be redirected to put more emphasis on supporting families	3.57(.88)	1	9	37	39	14

N=339

Table C-3: Descriptive statistics of perceptions of support for services from others.

	Mean (SD)	NA %	Highly Object 1 %	Somewhat Object 2 %	Neutral 3 %	Somewhat Approve 4 %	Highly Approve 5 %
Staff you supervise	4.43(.76)	38	<1	<1	7	19	35
Professional peers	4.35(.75)	7	<1	2	7	38	45
Immediate supervisor	4.46(.74)	13	1	1	7	29	50
Board's chairperson	3.96(.85)	14	<1	3	22	35	25
Board committee members	3.87(.83)	15	<1	4	23	38	20
Agency's executive director	4.15(.81)	12	0	3	15	36	34
Agency's top administration	4.09(.87)	12	<1	4	15	36	32
Agency's developmental disabilities services administration	4.42(.78)	14	<1	2	7	28	49
Agency's developmental disabilities services staff	4.47(.76)	7	<1	2	7	28	55
Agency's family support services staff	4.67(.63)	11	<1	<1	5	17	66
Self	4.73(.53)	2	<1	0	2	21	74

N=339

Table C-4: Descriptive statistics of belief/perception items regarding forces which hinder or facilitate the implementation of family support services.

What do you think?	Mean(SD)	Very Untrue 1 %	Somewhat Untrue 2 %	Neither 3 %	Somewhat True 4 %	Very True 5 %
My board/agency has sufficient capacity to provide adequate support services to all families in our community who need/want them.	2.09(1.16)	39	36	4	20	1
In general, people at my board/ agency are not interested in providing services for families.	1.63(.91)	59	27	8	5	1
My board/agency lacks sufficient staff resources to provide adequate family support services.	3.77(1.17)	5	15	8	43	30
Providing support services for families is a top budget priority at my board/agency.	2.84(1.11)	13	28	28	27	5
State Department funding allocations have helped my board/agency's ability to provide family support services.	3.24(1.26)	16	13	13	48	10
My board/agency has provided the necessary opportunities for staff to improve their knowledge and learn the skills required to provide support services to families.	3.62(1.11)	5	16	11	48	20

Table C-4 (cont'd).

What do you think?	Mean(SD)	Very Untrue 1 %	Somewhat Untrue 2 %	Neither 3 %	Somewhat True 4 %	Very True 5 %
There is a sufficient number of qualified service providers (e.g. for respite care, in-home nursing, in-home behavioral management training, etc.) in our community to support my board/ agency's efforts to provide family support services.	2.40(1.23)	26	40	5	23	5
Families in our community have been very active in advocating for the development and/or expansion of family support services at my board/agency.	2.97(1.25)	14	27	16	33	10
In general, people at my board/agency lack a clear understanding of what family support services are.	2.92(1.24)	15	28	16	33	8
My board/agency has lacked the funding capacity to develop family support services.	3.68(1.17)	5	15	14	38	18
My board has hired people who have the expertise needed to provide support services to families.	3.64(1.13)	5	15	12	45	22
The various agencies and professionals who work with families in our community readily refer families to my board/agency for the services we provide.	3.98(.99)	2	9	10	46	32

Table C-4 (cont'd).

What do you think?	Mean(SD)	Very Untrue 1 %	Somewhat Untrue 2 %	Neither 3 %	Somewhat True 4 %	Very True 5 %
Our mental health board committee members are committed to the development and/or expansion of family support services.	3.44(.92)	2	13	33	42	10
My board/agency has not been able to keep up with the demand for family support services, families have had to wait to get into the program or to receive services.	3.59(1.25)	8	15	13	38	27
Families have been reluctant to take advantage of the services available at my board/agency.	2.47(1.12)	23	33	19	24	1
My board/agency's administration is committed to the development and/or expansion of family support services.	3.56(.92)	1	13	26	46	13
There is a general lack of community interest and involvement in supporting individuals with disabilities and their families.	2.77(1.08)	10	38	22	26	4
The system does not recognize the family as the client, only the individual with disabilities, which hinders our efforts to implement support services for families.	3.26(1.26)	10	22	18	33	18

Table C-4 (cont'd).

What do you think?	Mean(SD)	Very Untrue 1 %	Somewhat Untrue 2 %	Neither 3 %	Somewhat True 4 %	Very True 5 %
The attitudes and practices of most service providers in our community are that support services should be provided only to the individual with disabilities, they do not involve or support the family.	2.51(1.12)	18	41	17	21	4
Families in our community really don't want family support services.	1.59(.83)	59	27	11	3	1

(*N*=339)

Table C-5: Principal axis factoring of attitude items after varimax rotation.

	Factors					
Factor statistics	I	II	III	IV	V	VI
Eigenvalue (before rotation)	8.0	2.0	1.6	1.4	1.2	1.0
Percent of variance (after rotation)	27.8	5.5	3.6	3.0	2.2	1.8
Items (abbreviated)						
Don't think there is a need for FSS (R)	.76	.21	.14	.06	.12	.00
Not convinced FSS is effective or appropriate (R)	.67	.29	.04	.12	.20	.08
Parents views are important to services planning	.55	.39	.11	.13	-.00	.01
Like to see agency discontinue FSS (R)	.53	.16	.09	.06	.13	.11
Do not see strong enough need to warrant further development of FSS (R)	.52	.24	.39	.12	.13	.10
Families have help from others, mental health should not be using resources too (R)	.49	.01	.23	.26	.34	.28
Parents should be actively involved in services planning	.48	.39	.13	.19	-.04	.03
Family support takes up too much staff time better devoted to other services (R)	.40	.36	.19	.28	.23	.31
^Families supported by school system, no need for mental health to also do so (R)	.35	.06	.15	.26	.25	.09
Parents are knowledgeable and competent resources and should be involved	.18	.57	.05	-.01	.04	.18
Families not capable care givers (R)	.12	.52	-.02	.29	.18	.25
Family support concepts should be agency's way of doing business	.34	.48	.22	.19	.15	-.01
Services more effective when family centered and driven	.20	.47	.16	.11	.13	-.21
Personally committed to FSS	.23	.46	.36	-.09	.18	.07
Supporting families should be top priority at agency	.27	.46	.29	.29	.12	-.02
Like to help others implement FSS	.15	.39	.23	.09	.01	.02
Agency should redirect resources to provide more FSS	.08	.06	.74	.19	.03	.09
Staff resources should be redirected, more emphasis FSS	.11	.25	.68	.19	.02	-.11
FSS should be greater percentage of agency budget	.19	.20	.61	.13	-.05	.36
Would like to see agency expand or improve FSS	.36	.29	.43	-.19	-.14	.27
^Would like to know what other agencies are doing	.22	.11	.27	.06	-.25	.05

Table C-5 (cont'd).

	Factors					
Items (abbreviated)	I	II	III	IV	V	VI
Focus on person with disability, not family (R)	.11	.11	.21	.58	-.05	.02
Services for individuals priority over services for family (R)	.11	.11	.06	.48	.12	.07
Agency should find out more about FSS before going further (R)	.12	.04	.12	.06	.58	-.01
FSS require too much change (R)	.16	.19	-.10	-.00	.50	.02
^FSS not in domain of mental health responsibility (R)	.09	.14	.18	.19	.33	.19
^Other needs should be addressed first (R)	.26	.10	.33	.22	.09	.44

(R) identifies items which were reverse scored for factor analysis.

^ identifies items deleted in final factor analysis.

Note. Six factors accounted for 57% of the variance prior to rotation.

Table C-6: Principal axis factoring of belief/perception items after varimax rotation.

	Factors					
Factor statistics	I	II	III	IV	V	VI
Eigenvalue (before rotation)	8.2	2.6	2.2	1.9	1.5	1.0
Percent of variance (after rotation)	25.1	7.0	5.3	4.4	2.7	1.7
Items (abbreviated)						
Board committee members are supportive	.77	.21	-.12	.09	.21	.23
Agency's executive director is supportive	.74	.23	.03	.03	.11	.32
Agency's top administration is supportive	.74	.33	.08	.10	.08	.03
Board chairperson is supportive	.73	.38	.01	.08	.06	.08
Board committee members committed to develop/expand FSS	.73	.02	.26	.03	.07	-.11
Agency's administration is committed to develop/expand FSS	.72	.10	.21	-.02	.11	-.12
People at agency are not interested in providing FSS (R)	.63	.18	.19	-.01	.16	.00
Providing FSS is a top budget priority	.55	-.01	.36	.12	.06	-.05
People at agency lack clear understanding of FSS (R)	.44	.10	.23	.01	.28	-.12
Self is supportive of FSS	.12	.74	.09	.05	-.11	.02
Agency's developmental disabilities staff is supportive	.23	.73	-.04	.05	.19	-.15
FSS staff is supportive	.13	.73	.13	-.02	.04	-.12
Professional peers are supportive	.14	.69	.11	-.08	.15	.09
Staff supervised are supportive	.18	.64	.15	.07	.18	.22
Developmental disabilities administration is supportive	.48	.58	-.11	.19	.08	-.14
Immediate supervisor is supportive	.29	.49	.20	.06	-.14	.30
Families don't want FSS (R)	-.00	.39	.39	-.05	.23	.05
Community agencies refer families to agency for services	.15	.10	.53	-.12	-.08	.09
Families active in advocating for FSS	.18	.01	.47	.05	.15	-.04
^Agency hired staff with FSS expertise	.32	.14	.45	.11	.13	-.17
Families reluctant to take advantage of services (R)	.04	.16	.41	-.15	.15	.01
^Agency provided FSS staff training opportunities	.35	.16	.37	.26	.06	-.05
^Sufficient resources in community to support agency's efforts to provide FSS	.09	-.08	.32	.19	.22	.02
^State department funding allocations support agency's FSS	.03	.09	.32	.31	-.13	.13
Agency has sufficient capacity	.06	-.03	-.02	.65	.12	.12

Table C-6 (cont'd).

Items (abbreviated)	Factors I	II	III	IV	V	VI
Agency lacks funding capacity (R)	.04	.11	.10	.61	.00	-.03
Agency lacks sufficient staff (R)	.12	.01	.05	.59	.07	-.14
Agency not able to keep up with demand, families wait (R)	-.03	-.03	-.30	.49	.02	.04
Attitudes and practices in community support individual services, not family services (R)	.18	.15	.13	.02	.58	.19
Lack of community interest in supporting individuals and families (R)	.12	.13	.15	.03	.43	-.09
System does not recognize family as client (R)	.28	-.00	-.00	.15	.40	-.07

(R) identifies items which were reverse scored for factor analysis.

^ identifies items not included in final factor analysis.

Note. Six factors accounted for 57% of the variance prior to rotation.

Table C-7: Attitude factors IV and V and belief/perception factor V internal reliability.

Items (abbreviated)	Inter-item *r* 1	2	Corrected Item-total *r*	Alpha
Attitude factor IV:				
Individual program priority over FSS			.38	
Focus of service on individual, not family	.38		.38	.55
Attitude factor V (behavioral intentions):				
FSS require too much change			.37	
Should find out more about FSS	.37		.37	.54
Belief/perception factor V:				
Lack of community interest			.24	
System does not recognize family	.21		.28	
Attitudes and practices of community service providers don't support families	.24	.23	.29	.47

Table C-8: Correlation between criteria and items and factors not included in final predictor scales.

Factors/items (abbreviated)	Criteria: Number of Services	Criteria: Administrative Formalization
Other needs in community are more pressing	-.39**	-.05
FSS not within mental health domain	-.24	.00
Like to know what other agencies are doing	.12	-.11
Families supported by school system, not necessary for mental health to do also	-.25	-.21
State funding allocations have helped	.11	.26
Attitude factor IV:	-.27*	-.10
Individual program priority over FSS	-.26	-.18
Focus of service on individual, not family	-.18	.05
Attitude factor V (behavioral intentions):	-.35**	-.34*
FSS require too much change	-.24	-.27*
Should find out more about FSS	-.39**	-.33*
Belief/perception factor V:	-.07	-.15
Lack of community interest	-.09	-.13
System does not recognize family	.09	-.08
Attitudes and practices of community service providers don't support families	-.16	-.14

* $p < .05$, ** $p < .01$, two-tailed.

BIBLIOGRAPHY

Alexander, E. (1985). From idea to action: Notes for a contingency theory of policy implementation process. Administration and Society, 16(4), 403-426.

Agosta, John. (1989). Using cash assistance to support family efforts. In G. H. S. Singer & L. K. Irvin (Eds.), Support for care giving families: Enabling positive adaptation to disability (pp. 189-204). Baltimore: Brookes.

Agosta, J. M. & Bradley, V. J. (Eds.) (1985). Family care for persons with developmental disabilities: A growing commitment. Boston, MA: Human Services Research Institute.

Agosta, J., Bradley, V., Rugg, A., Spence, R. & Covert, S. (1985). Designing programs to support family care for persons with developmental disability: Concepts to practice. Boston, MA: Human Services Research Institute.

Agosta, J. M., Jennings, D. & Bradley, V. J. (1985). Statewide family support programs: National survey results. In J. M. Agosta & V. J. Bradley (Eds.), Family care for persons with developmental disabilities: A growing commitment (pp. 94-112). Boston, MA: Human Services Research Institute.

Ajzen, I. & Fishbein, M. (1980). Understanding attitudes and predicting social behavior. Englewood Cliffs, NJ: Prentice Hall.

Arneaud, S. & Herman, S. E. (1989). Family support subsidy program: Annual report to the governor and the legislature. Lansing: Michigan Department of Mental Health.

Attewell, P. & Gerstein, D. R. (1979). Government policy and local practice. American Sociological Review, 44, 311-327.

Ayer, Sam. (1984). Community care: Failure of professionals to meet family needs. Child: Care, Health and Development, 10, 127-140.

Backer, T. E., Liberman, R. P., Kuehnel, T. G. (1986). Dissemination and adoption of innovative psychosocial interventions. Journal of Consulting and Clinical Psychology, 54(1), 111-118.

Baldridge, J. V. & Burnham, R. A. (1975). Organizational innovation: Individual, organizational and environmental impacts. Administrative Science Quarterly, 20, 165-176.

Bardach, Eugene. (1977). The implementation game: What happens after a bill becomes a law. Cambridge, MA: MIT Press.

Beckman, Paula J. (1983). Influence of selected child characteristics on stress in families of handicapped infants. American Journal of Mental Deficiency, 88(2), 150-156.

Berman, P. & McLaughlin, M. W. (1977). Federal programs supporting educational change, Vol. VII: Factors affecting implementation and continuation. Santa Monica, CA: Rand Corporation.

Berman, P. & McLaughlin, M. W. (1978). Federal programs supporting educational change, Vol. VIII: Implementing and sustaining innovations. Santa Monica, CA: Rand Corporation.

Blacher, Jan. (Ed.) (1984). Severely handicapped young children and their families: Research in review. New York: Academic Press.

Blakely, C. H., Mayer, J. P., Gottschalk, R. G., Schmitt, N., Davidson, W. S., et al. (1987). The fidelity-adaptation debate: Implications for the implementation of public sector social programs. American Journal of Community Psychology, 15, 253-268.

Botuck, S. & Winsberg, B. G. (1991). Effects of respite on mothers of school-age and adult children with severe disabilities. Mental Retardation, 29(1), 43-47.

Breslau, N. & Prabucki, K. (1987). Siblings of disabled children: Effects of chronic stress in the family. Archives of General Psychiatry, 44, 1040-1048.

Bromley, B. & Blacher, J. (1989). Factors delaying out-of-home placement of children with severe handicaps. American Journal of Mental Retardation, 94(3), 284-291.

Bronfenbrenner, U. (1986). The ecology of the family as a context for human development: Research Perspectives. Developmental Psychology, 22(6), 723-742.

Browning, R. P., Marshall, D. R. & Tabb, D. H. (1981). Implementation and political change: Sources of local variations in federal social programs. In D. A. Mazmanian and P. A. Sabatier (Eds.), Effective policy implementation (pp. 127-146). Lexington, MA: Lexington Books.

Bruininks, R. H. & Krantz, G. C. (Eds.) (1979). Family care of developmentally disabled members: Conference proceedings. Minneapolis: University of Minnesota.

Byrne, E. A. & Cunningham, C. C. (1985). The effects of mentally handicapped children on families: A conceptual review. Journal of Child Psychology & Psychiatry & Allied Disciplines, 26(6), 847-864.

Castellani, P. J., Downey, N. A. Tausig, M. B. & Bird, W. A. (1986). Availability and accessibility of family support services. Mental Retardation, 24(2), 71-79.

Cavanagh, J. & Ashman, A. F. (1985). Stress in families with handicapped children. Australian & New Zealand Journal of Developmental Disabilities, 11(3), 151-156.

Center on Human Policy (1987, Sept.). Families for all children. Syracuse, NY: author.

Cernoch, Jennifer. (1989). Respite care: A gift of time. NICHCY News Digest, 12, 1-9.

Chetwynd, Jane. (1985). Factors contributing to stress on mothers caring for an intellectually handicapped child. British Journal of Social Work, 15(3), 295-304.

Cohen, Shirley. (1982). Supporting families through respite care. Rehabilitation Literature, 43(1-2), 7-11.

Cohen, S. Agosta, J., Cohen, J. & Warren R. (1989). Supporting families of children with severe disabilities. Journal of the Association for Persons with Severe Handicaps, 14(2), 155-162.

Cole, D. A. & Meyer, L. H. (1989). Impact of needs and resources on family plans to seek out-of-home placement. American Journal of Mental Retardation, 93(4), 380-387.

Cronbach, Lee J. (1951). Coefficient alpha and the internal structure of tests. Psychometrika, 16(3), 297-334.

Darling, Rosalyn B. (1983). Parent-professional interaction: The roots of misunderstanding. In M. Seligman (Ed.), The family with a handicapped child: Understanding and treatment (pp. 95-121). New York: Grune & Stratton.

Darling, Rosalyn B. (1988). Parental entrepreneurship: A consumerist response to professional dominance. Journal of Social Issues, 44(1), 141-158.

Davis, Donald D. (1982). Innovation adoption and organization change: Program evaluation in gerontology. Unpublished doctoral dissertation, Michigan State University, East Lansing.

DeVellis, Robert F. (1991). Scale development: Theory and applications. Newbury Park, CA: Sage.

Downs, George W., Jr. (1976). Bureaucracy, innovation, and public policy. Lexington, MA: Lexington Books.

Dunst, C. J. & Trivette, C. M. (1981). An enablement and empowerment perspective of case management. Topics in Early Childhood Education, 8(4), 87-102.

Dunst, C., Trivette, C. & Deal, A. (1988). Enabling and empowering families: Principles and guidelines for practice. Cambridge, MA: Brookline Books.

Dunst, C. J., Trivette, C. M., Gordon, N. J. & Pletcher, L. L. (1989). Building and mobilizing informal family support networks. In G. H. S. Singer & L. K. Irvin (Eds.), Support for care giving families: Enabling positive adaptation to disability (pp. 121-141). Baltimore: Brookes.

Edwards, George C. (1980). Implementing public policy. Washington, DC: Congressional Quarterly Press.

Elmore, Richard F. (1979). Backward mapping: Implementation research and policy decisions. Political Science Quarterly, 94(4), 601-616.

Elmore, Richard F. (1985). Forward and backward mapping: Reversible logic in the analysis of public policy. In K. Hanf and T. Toonen (Eds.), Policy implementation in federal and unitary systems (pp. 33-70). Dordrecht, Netherlands: Martinus Nijhoft.

Factor, D. C., Perry, A. & Freeman, N. (1990). Stress, social support, and respite care use in families with autistic children. Journal of Autism and Developmental Disorders, 20(1), 139-146.

Fairweather, G. W. & Tornatzky, L. G. (1977). Experimental methods for social policy research. New York: Pergamon.

Fairweather, G. W., Sanders, D. H. & Tornatzky, L. G. (1974). Creating change in mental health organizations. New York: Pergamon.

Fox, John. (1991). Regression diagnostics. Newbury Park, CA: Sage.

Frank, S. J. & Davidson, D. S. (1983). Ideologies and intervention strategies in an urban sample of drug-abuse agencies. American Journal of Community Psychology, 11(3), 241-259.

Gallagher, J. J., Beckman, P. & Cross, A. H. (1983). Families of handicapped children: Sources of stress and its amelioration. Exceptional Children, 50, 10-19.

Gallagher, J. J. & Gallagher, G. G. (1985). Family adaptation to a handicapped child and assorted professionals. In H. R. Turnbull & A. P. Turnbull (Eds.), Parents speak out: Then and now (pp. 233-242). Columbus, OH: Charles E. Merrill.

Gallagher, J. J. & Vietze, P. M. (Eds.). (1986). Families of handicapped persons: Research, programs, and policy issues. Baltimore: Brookes.

Ghiselli, E. E., Campbell, J. P. & Zedeck, S. (1981). Measurement theory for the behavioral sciences. San Francisco: W. H. Freeman.

Glaser, E. M., Abelson, H. H. & Garrison, K. N. (1983). Putting knowledge to use: Facilitating the diffusion of knowledge and the implementation of planned change. San Francisco: Jossey-Bass.

Grant, G. & McGrath, M. (1990). Need for respite care services for care givers of persons with mental retardation. American Journal of Mental Retardation, 94(6), 638-648.

Hage, J. & Dewar, R. (1973). Elite values versus organizational structure in predicting innovation. Administrative Science Quarterly, 18, 279-290.

Hall, G. E. & Loucks, S. F. (1978). Innovation configurations: Analyzing the adaptations of innovations. Austin: University of Texas at Austin, Research and Development Center for Teacher Education.

Halpern, Peggy L. (1985). Respite care and family functioning in families with retarded children. Health & Social Work, 10(2), 138-150.

Halpern, Robert. (1986). Home-based early intervention: Dimensions of current practice. Child Welfare, 65(4), 387-398.

Havelock, R. C. (1971). Planning for innovation through dissemination and utilization. Ann Arbor: University of Michigan.

Hasenfeld, Y. & Brock, T. (1991). Implementation of social policy revisited. Administration and Society, 22(4), 451-479.

Hazel, K. L., Herman, S. E., Thompson, L., Linklater, A. (1990). Survey of Community Mental Health Family Support Services. Lansing: Michigan Department of Mental Health.

Herman, S. E. (1983). Family support services: Report on meta-evaluation study. Lansing: Michigan Department of Mental Health.

Herman, S. E. (1984). Baseline study of family support services in the State of Michigan. Lansing: Michigan Department of Mental Health.

Herman, S. E. (1986). Report on family support subsidy program FY84-85. Lansing: Michigan Department of Mental Health.

Herman, S. E. (1991). Use and impact of a cash subsidy program. Mental Retardation, 29(5), 253-258.

Herman, S. E. & Hazel, K. L. (1987). Family support services in Michigan: An evolving system. Lansing: Michigan Department of Mental Health.

Herman, S. E. & Hazel, K. L. (1991, in press). Evaluation of family support services: Changes in availability and accessibility. Mental Retardation, 29(6).

Herman, S. E., Hazel, K. L. & Marcenko, M. O. (1989). Quality family support evaluation: Interim report to the Michigan Developmental Disabilities Council. Lansing: Michigan Department of Mental Health.

Herman, S. E., Marcenko, M. O. & Hazel, K. L. (1991). Family support services: Evaluation of program quality. Lansing: Michigan Department of Mental Health.

Herman, S. E., Hazel, K. L., Thompson, T. L. & Linklater, A. (1992a). Family Support Services in Michigan: Respite Care. Lansing, MI: Michigan Developmental Disabilities Council.

Herman, S. E., Hazel, K. L., Thompson, T. L. & Linklater, A. (1992b). Family Support Services in Michigan: Parent Advisory Committees at Community Mental Health. Lansing, MI: Michigan Developmental Disabilities Council.

Herman, S. E., Thompson, T. L., Linklater, A. & Hazel, K. L. (1992). Family Support Services in Michigan: Community Mental Health Family Support Services. Lansing, MI: Michigan Developmental Disabilities Council.

Hinckley, E. C. & Ellis, W. F. (1985). An effective alternative to residential placement: Home-based services. Journal of Clinical Child Psychology, 14(3), 209-213.

Hunter, John E. (1980). Factor analysis. In P. Monge and J. Capella (eds.), Multivariate techniques in human communication research (p. 229-257). New York: Academic Press.

Hunter, J. E. & Hamilton, Mark A. (1992). Path: A program in basica. Statistical software available from first author, Psychology Department, Michigan State University, East Lansing, MI 48824-1117.

Ineichen, Bernard. (1986). A job for life? The service needs of mentally handicapped people living in the community, and their families. British Journal of Social Work, 16(3), 311-323.

Ingram, H. M. & Mann, D. E. (Eds.). (1980). Why policies succeed or fail? Beverly Hills, Sage.

Ireys, H. T. & Eichler, R. J. (1988). Program priorities of crippled children's agencies: A survey. Public Health Reports, 103(1), 77-83.

Ireys, H. T., Hauck, R. & Perrin, J. (1985). Variability among state crippled children's service programs: Pluralism thrives. American Journal of Public Health, 75(4), 375-381.

Johnson, R. W. & O'Connor, R. E. (1979). Intraagency limitations on policy implementation: You can't always get what you want, but sometimes you get what you need. Administration & Society, 11(2), 193-215.

Joyce, K., Singer, M. & Isralowitz, R. (1983). Impact of respite care on parents' perceptions of quality of life. Mental Retardation, 21(4), 153-156.

Justice, R. S., O'Connor, C. & Warren, N. (1971). Problems reported by parents of mentally retarded children--Who helps? American Journal of Mental Deficiency, 75(6), 685-691.

Kagan, S. L., Powell, D. R., Weissbourd, B. & Zigler, E. F. (1987). Past accomplishments: Future challenges. In S. Kagan, D. Powell, B. Weissbourd and E. Zigler (Eds.), America's family support programs: Perspectives and prospects (pp. 365-380) New Haven: Yale University Press.

Katz, R. F. (1984). Empowerment and synergy: Expanding the community's healing resources. In J. Rappaport, C. Swift and R. Hess (Eds.), Studies in empowerment: Steps toward understanding and action (pp. 201-226). New York: Haworth Press.

Kazak, Anne E. (1987). Families with disabled children: Stress and social networks in three samples. Journal of Abnormal Child Psychology, 15(1), 137-146.

Kimberly, J. R. & Evanisko, M. J. (1981). Organizational innovation: The influence of individual, organizational, and contextual factors on hospital adoption of technological and administrative innovations. Academy of Management Journal, 24, 689-713.

Kirst, M. & Jung, R. (1980). The utility of a longitudinal approach in assessing implementation: A thirteen-year view of Title 1, ESEA. Education Evaluation and Policy Analysis, 2(5), 17-34.

Knoll, J. A., Covert, S., Osuch, R., O'Connor, S., Agosta, J., Blaney, B. & Bradley, V. J. (1990). Family support services in the United States: An end of decade status report. Cambridge, MA: Human Services Research Institute.

Krauss, M. W. (1986). Patterns and trends in public services to families with a mentally retarded member. In J. J. Gallagher & P. M. Vietze (Eds.), Families of handicapped persons: Research, programs, and policy issues (pp. 237-248). Baltimore: Brooks.

Landesman, S. & Butterfield, E. C. (1987). Normalization and deinstitutionalization of mentally retarded individuals. American Psychologist, 42(8), 809-816.

Legge, K. (1984). Evaluating planned organizational change. New York: Academic Press.

Levine, R. L., Van Sell, M. & Rubin, B. (1992). System dynamics and the analysis of feedback processes in social and behavioral systems. In R. L. Levine and H. E. Fitzgerald (eds.), Analysis of dynamic psychological systems [vol. 1] (pp. 145-266). New York: Plenum.

Lewin, K. (1951). Psychological ecology. In D. Cartwright (Ed.), Field theory in social science (pp. 170-187). New York: Harper.

Lewis-Beck, Michael, S. (1980). Applied regression: An introduction. Beverly Hills: Sage.

Likert, R. (1932). A technique for the measurement of attitudes. Archives of Psychology. No. 140.

Lutzer, V. D. & Brubaker, T. H. (1988). Differential respite needs of aging parents of individuals with mental retardation. Mental Retardation, 26(1), 13-15.

Majone, G. & Wildavsky, A. (1978). Implementation as evolution. Policy Studies Review Annual, 2, 103-117.

Marc, D. & MacDonald, L. (1988). Respite care: Who uses it? Mental Retardation, 26(2), 93-96.

Mazmanian, D. A. & Sabatier, P. A. (Eds.). (1981). Effective policy implementation. Lexington, MA: Lexington Books.

Mazmanian, D. A. & Sabatier, P. A. (1983). Implementation and public policy. Chicago: Scott Foresman and Co.

McKinney, B. & Peterson, R. A. (1987). Predictors of stress in parents of developmentally disabled children. Journal of Pediatric Psychology, 12(1), 133-150.

McLaughlin, M. (1987). Learning from experience: Lessons from policy implementation. Educational Evaluation and Policy Analysis, 9(2), 171-178.

Meisels, Samuel J. (1989). Meeting the mandate of public law 99-457: Early childhood intervention in the nineties. American Journal of Orthopsychiatry, 59(3), 451-460.

Meyers, J. C. & Marcenko, M. O. (1989). Impact of a cash subsidy program for families of children with severe developmental disabilities. Mental Retardation, 27(6), 383-387.

Michigan Department of Commerce. (1990). Michigan rural development strategy: Data book. Lansing, MI: Author.

Michigan Department of Mental Health. (1984). Public Mental Health Manual: Community Mental Health Family Support Services for the Developmentally Disabled (Vol. 4, Sec. 2, Chapter. G, pp. 1-6). Lansing, MI: Author.

Michigan Department of Mental Health. (1986). Michigan mental health code [family support subsidy pp. 9-13]. Lansing: Author.

Michigan Department of Mental Health. (1988). Public Mental Health Manual: Family support services for persons with developmental disabilities (Vol. 4, Sec. 2, Chapter. G, pp. 1-8). Lansing, MI: Author.

Michigan Developmental Disabilities Council. (1988). Family support action plan. Lansing, MI: Author.

Moch, M. K. & Morse, E. V. (1977). Size, centralization and organization adoption of innovations. American Sociological Review, 42(5), 716-725.

Moroney, R. M. (1979). Allocation of resources for family care. In R. H. Bruininks & G. C. Krantz (Eds.), Family care of developmentally disabled members: Conference proceedings (pp. 63-76). Minneapolis: University of Minnesota.

Moroney, Robert M. (1986). Shared responsibility: Families and social policy. New York: Aldine de Gruyter.

Mowbray, C. T. & Herman, S. E. (1991). Using multiple sites in mental health evaluations: Focus on program theory and implementation issues. New Directions for Program Evaluation, 50, 45-57.

Nord, W. R. & Tucker, S. (1987). Implementing routine and radical innovations. Lexington, MA: Lexington Books.

Norusis, Mariza J. (1988). SPSS-X Advanced statistics guide [2nd ed.]. Chicago: SPSS Inc.

Parrot, M. E. & Herman, S. E. (1987). Michigan department of mental health report on family support subsidy program FY85-86. Lansing: Michigan Department of Mental Health.

Parrot, M. E. & Herman, S. E. (1988). Family support subsidy program report FY1986-87. Lansing: Michigan Department of Mental Health.

Perlman, R. & Gicle, J. Z. (1983). An unstable triad: Dependents' demands, family resources, community supports. In R. Perlman (Ed.), Family home care: Critical issues for services and policies (pp. 12-44). New York: Haworth Press.

Quine, L. & Pahl, J. (1985). Examining the causes of stress in families with severely mentally handicapped children. British Journal of Social Work, 15(5), 501-517.

Rappaport, Julian. (1987). Terms of empowerment/Exemplars of prevention: Toward a theory of community psychology. American Journal of Community Psychology, 15(2), 121-144.

Rice, R. E. Rogers, E. M. (1980). Reinvention in the innovation process. Knowledge: Creation, Diffusion, Utilization, 1(4), 499-514.

Rimmerman, A. (1989). Provision of respite care for children with developmental disabilities: Changes in maternal coping and stress over time. Mental Retardation, 27(2), 99-103.

Roberts, R. N., Wasik, B. H., Casto, G. & Ramey, C. T. (1991). Family support in the home: Programs, policy, and social change. American Psychologist, 46(2), 131-137.

Rogers, Everett M. (1983). Diffusion of innovations [Third edition]. New York: Free Press.

Roitman, David B. (1984). Innovation in public sector organizations: A test of the modified RD&D approach. Unpublished doctoral dissertation, Michigan State University, East Lansing.

Rowitz, Louis. (1985). Social support: The issue for the 1980s. Mental Retardation, 23(4), 165-167.

Rubin, S. & Quinn-Curran, N. (1983). Lost, then found: Parents' journey through the community service maze. In M. Seligman (Ed.), The family with a handicapped child: Understanding and treatment (pp. 63-94). New York: Grune & Stratton.

Sabatier, P. A. (1987a). Knowledge, policy-oriented learning, and policy change: An advocacy coalition framework. Knowledge: Creation, diffusion, utilization, 8(4), 649-692.

Sabatier, P. A. (1987b). Top-down and bottom-up approaches to implementation research: A critical analysis and suggested synthesis. Journal of Public Policy, 6, 21-48.

Sabatier, P. A. & Mazmanian, D. A. (1981). The implementation of public policy: A framework of analysis. In D. A. Mazmanian and P. A. Sabatier (Eds.), Effective policy implementation (pp. 3-35). Lexington, MA: Lexington Books.

Salisbury, C. L. & Intagliata, J. (1986). Respite care: Support for persons with developmental disabilities and their families. Baltimore: Brookes.

Scheirer, Mary. A. (1981). Program implementation: The organizational context. Beverly Hills, CA: Sage.

Schroeder, Pat. (1989). Toward a national family policy. American Psychologist, 44(11), 1410-1413.

Seligman, Milton. (Ed.) (1983). The family with a handicapped child: Understanding and treatment. New York: Grune & Stratton.

Seltzer, M. M. & Krauss, M. W. (1984). Placement alternatives for mentally retarded children and their families. In J. Blacher (Ed.), Severely handicapped young children and their families (pp. 143-175). New York: Academic Press.

Sherman, Barry R. (1988). Predictors of the decision to place developmentally disabled family members in residential care. American Journal of Mental Retardation, 92(4), 344-351.

Sherman, B. R. & Cocozza, J. J. (1984). Stress in families of the developmentally disabled: A literature review of factors affecting the decision to seek out-of-home placements. Family Relations, 33, 95-103.

Sigelman, L., Roeder, P. W. & Sigelman, C. K. (1981). Social service innovation in the American states: Deinstitutionalization of the mentally retarded. Social Sciences Quarterly, 62(3), 503-515.

Singer, G. H. S. & Irvin, L. K. (Eds.) (1989). Support for care giving families: Enabling positive adaptation to disability. Baltimore: Brookes.

Slater, M. A. & Wikler, L. (1986). 'Normalized' family resources for families with a developmentally disabled child. Social Work, 31(5), 385-390.

Soyka, P. (1976). Homemaker home health aide service for handicapped children. Child Welfare, 55, 241-251.

Starkey, J. & Sarli, P. (1989). Respite and family support services: Responding to the need. Child and Adolescent Social Work, 6(4), 313-326.

Stewart, David W. (1984). Secondary research: Information sources and methods. Beverly Hills: Sage.

Summers, J. A., Behr, S. K. & Turnbull, A. P. (1989). Positive adaptation and coping strengths of families who have children with disabilities. In G. H. S. Singer and L. K. Irvin (Eds.), Support for care giving families: Enabling positive adaptation to disability (pp. 27-40). Baltimore: Brookes.

Tausig, Mark. (1988). Personal support networks: Benefits and liabilities. Mental Retardation, 26(1), 47-49.

Taylor, S. J., Knoll, J. A., Lehr, S. & Walker, P. M. (1989). Families for all children: Value-based services for children with disabilities and their families. In G. H. S. Singer and L. K. Irvin (Eds.), Support for care giving families: Enabling positive adaptation to disability (pp. 41-53). Baltimore: Brookes.

Turnbull, A. P., Brotherson, M. J. & Summers, J. A. (1985). The impact of deinstitutionalization on families: A family systems approach. In R. H. Bruininks & K. C. Lakin (Eds.), Living and learning in the least restrictive environment (pp. 115-152). Baltimore: Brookes.

Turnbull, A. P., Summers, J. A. & Brotherson, M. J. (1986). Family life cycle: Theoretical and empirical implications and future directions for families with mentally retarded members. In J. J. Gallagher & P. M. Vietze (Eds.), Families of handicapped persons: Research, programs, and policy issues (pp. 45-66). Baltimore: Brookes.

Upshur, Carole C. (1982). Respite care for mentally retarded and other disabled populations: Program models and family needs. Mental Retardation, 20(1), 2-6.

Van de Ven, A. H. & Rogers, E. M. (1988). Innovations and organizations: Critical perspectives. Communication Research, 15(5), 632-651.

Van Meter, D. S. & Van Horn, C. E. (1975). The policy implementation process: A conceptual framework. Administration and Society, 6(4), 445-488.

Weiss, Heather B. (1988). Family support and education programs: Working through ecological theories of human development. In H. Weiss and F. Jacobs (Eds.), Evaluating family program (pp. 3-36). New York: Aldine de Gruyter.

Weiss, Heather B. (1989). State family support and education programs: Lessons from the pioneers. American Journal of Orthopsychiatry, 59(1), 32-48.

Weissbourd, B. & Kagan, S. L. (1989). Family support programs: Catalysts for change. American Journal of Orthopsychiatry, 59(1), 20-31.

Wiegerink, R. & Comfort, M. (1987). Parent involvement: Support for families of children with special needs. In S. Kagan, D. Powell, B. Weissbourd and E. Zigler (Eds.), America's family support programs: Perspectives and prospects (pp. 182-206) New Haven: Yale University Press.

Wikler, Lynn M. (1986). Family stress theory and research on families of children with mental retardation. In J. J. Gallagher & P. M. Vietze (Eds.), Families of handicapped persons: Research, programs, and policy issues (pp. 167-195). Baltimore: Brookes.

Winton, Pamela. (1986). The developmentally delayed child within the family context. Advances in Special Education, 5, 219-255.

Yin, Robert K. (1981, Jan.). Life histories of innovations: How new practices become routinized. Public Administration Review, 21-28.

Yin, Robert K. (1982). Studying the implementation of public programs. In W. Williams et al., Studying implementation: Methodological and administrative issues (pp. 36-72). Chatham, NJ: Chatham House.

Zaltman, G., Duncan, R. & Holbek, J. (1973). Innovations and Organizations. New York: Wiley.

Zigler, E. & Black, K. B. (1989). America's family support movement: Strengths and limitations. American Journal of Orthopsychiatry, 59(1), 6-19.