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SOCIAL FEEDBACK PROCESSES OF THE NEW HAMPSHIRE MENTAL HEALTH CENTERS

by

PRISCILLA REINERTSEN

M.A., University of New Hampshire, 1967

A DISSERTATION

Submitted to the University of New Hampshire

In Partial Fulfillment of

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This dissertation has been examined and approved.

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ABSTRACT

SOCIAL FEEDBACK PROCESSES OF THE

NEW HAMPSHIRE MENTAL HEALTH CENTERS

by

PRISCILLA S. REINERTSEN

A study of the social feedback processes of the mental health centers in New Hampshire was conducted for the dual purposes of enlarging our understanding of social feedback and control in complex human organizations, and of exploring the possibility of elaborating upon current theoretical and modeling work done in the area. It was intended that the findings of the study should be useful, not only to academicians and researchers, but also to decision-makers within complex organizations.

The design of the study was descriptive/exploratory. This was appropriate in the light of the small amount of empirical feedback research conducted on specific organizations. The principle research tool was the personal interview. A sample of four mental health centers intentionally drawn from a population of 13 served as the research subjects. Personnel in the Division of Mental Health, Community Mental Health Services department, and official center and Division publications were also included in the study. Together, 89 interviews of administrative staff, clerical staff, clinical staff, and Executive Board members were conducted.

The analyzed data revealed that social feedback in mental health centers is not a simple, well-ordered process. The regulation of the centers occurs both through the closed-loop process of feedback, and by the open-loop process of feedforward. Decisions on organizational and clinical goals and means are continually being made in response to both the consequences of action and to environmental information or disturbances. These two processes can be combined into an elaborated regulation model that would be applicable for any social organization.

Within mental health centers one finds two basic categories of decision-making: organizational/policy and clinical. Mental health staff tend to have a highly collegial relationship for joint decision-making, especially concerning clinical issues. The external feedback received by these staffs is largely unsystematic, while the internal feedback is systematic and unsystematic. This adds a degree of precariousness to the social feedback processes of the centers. Executive Board members receive little feedback altogether, and that received comes principally from the center Executive Director. The amount of feedback they receive is not commensurate with the weightiness of the decisions they are called upon to make. Instituted feedback systems at all levels within the mental health organization would help to insure that information for decisions to achieve maximum goal attainment was available.

SOCIAL FEEDBACK PROCESSES

OF THE

NEW HAMPSHIRE MENTAL HEALTH CENTERS

CHAPTER I

INTRODUCTION

In an attempt to understand human social organizations, their comings and goings, their evolutions, revolutions, dissolutions; systematic observers of group phenomena have focused their attentions on various categories of group action. The scholarly literature of the last 125 years, especially, is filled with queries and speculations, notations and analyses of conflict, cooperation, competition, communication and other social processes not beginning with C. Only as recently as 35 years ago, however, did the process of organizational self-regulation come to the fore of scientific scrutiny. This is a process of considerable popular familiarity, though of perhaps less scientific knowledge, based on the principle of social feedback.

Continuing from Norbert Wiener's work at the Massachusetts Institute of Technology in the 1940's in the area of cybernetics, the concept of feedback has been theorized about and usefully applied in many fields. Wiener took the Greek word 'cybernetics' and used it to mean "the science of control and communication in the animal and in the machine."[1] Feedback is the process by which information relating to goals is transmitted back to a control center. It is a type of reality

[1]Norbert Wiener, Cybernetics, (New York: Wiley, 1948) p. 6.

testing to learn the state of things with reference to an intended state or set of relationships. The control center, ideally, makes the appropriate adjustments if there is a discrepancy between the intended goals and the actual condition of the environment. Diagrammed very simply the process of self-regulation is as follows:

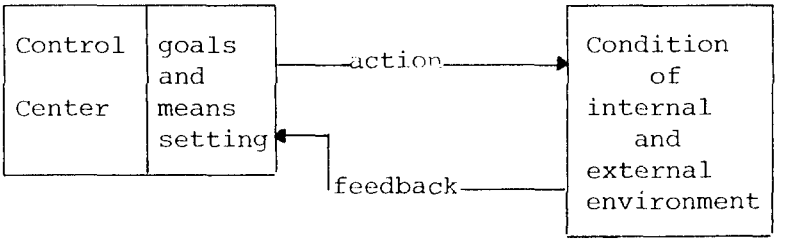

Figure 1. Process of self-regulation

The diagram implies that the organization, be it animal, machine, or otherwise, has the capacity of adjusting its activity in response to an ever-changing environment. And, as the environment and its sets of relationships are not static, the entire process, when functioning, is very dynamic and continuous.

The study of "control and communication" has opened up the concept of bio-feedback or biological self-regulation within a living organism. It has expanded the development of servo-mechanisms or closed-loop regulating systems in industry and engineering of all kinds. Aero-space research and modern weaponry systems are all based on the concepts of cybernetics. A few industries have become sensitized to the significance of feedback in policy and production quota establishment, implementation and re-establishment. General models employing feedback loops have proliferated from the fields of economics and business administration. These models tend to have universal implications for all animate and inanimate organizations including vastly complex systems such as cities

or megalopolises or the entire system of production, distribution, and consumption of goods and services.[2]

What seems to be lacking in all of this sophisticated research and development is a close look at the nature and the implications of social feedback for specific human organizations. Social feedback models, such as that discussed by Buckley (see Figure 2.) are helpful for explaining what tends to take place in group goal seeking.

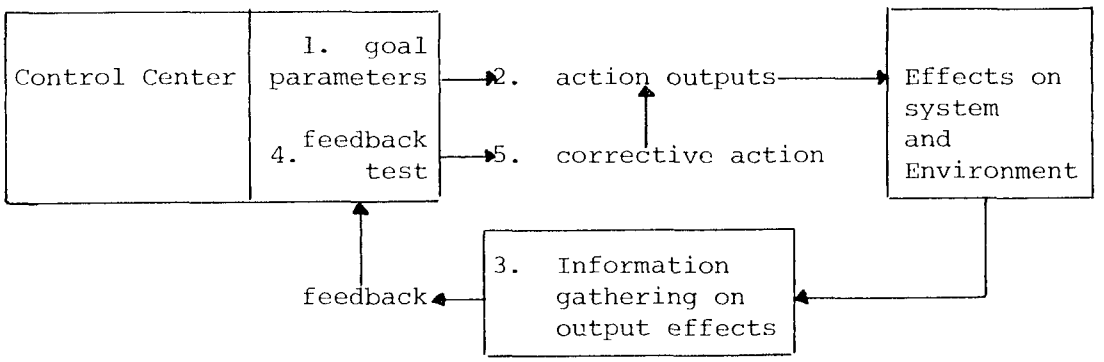

Figure 2. Taken from: W. Buckley, Sociology and Modern Systems Theory, (Englewood Cliffs, N.J.), Prentice-Hall, 1967, p. 173.

1) A control center establishes certain desired goal parameters and the means by which they may be attained; 2) these goal decisions are transformed by administrative bodies into action outputs, which result in certain effects on the state of the system and its environment; 3) information about these effects are recorded and fed back to the control center; 4) the latter tests this new state of the system against the desired goal parameters to measure the error or deviation of the initial out put response; 5) if the error leaves the system outside the limits set by the goal parameters, corrective output action is taken by the control center.[3]

[2]See especially: Jay W. Forrester, "A Deeper Knowledge of Social Systems", Technology Review, April 1969; Jay W. Forrester, Industrial Dynamics, Cambridge, Mass., The MIT Press, 1961; and Donella Meadows, et.al., The Limits to Growth, New York, Signet, 1972.

[3]Walter Buckley, Sociology and Modern Systems Theory, (Englewood Cliffs, N.J.: Prentice-Hall, 1967) p. 174.

But actual social systems and organizations are often highly complex and operate frequently through complicating circumstances. Control centers may be multiple, as are the feedback loops; feedback information may be selectively picked up and utilized; goals may be too ambiguous to be a standard of comparison with environmental conditions or may be difficult to measure. Feedback may return as an overload, too much to handle, or it may be insufficient and incomplete. Organizations in operation are far less rational than they would appear in diagrams of organizational responsibility and performance. Further, organizational behavior is only in part a function of feedback. The learning experiences of organizational members, their personal needs, beliefs, goals, the flow of economic, political, educational relationships all are a part of a larger picture of controlling influences. The weight of the influence of feedback is very much related to the characteristics of the feedback. Feedback may be: formal, informal, systematic, unsystematic, relatively rapid or delayed, oral, written, from direct observation, relatively accurate, relatively inaccurate, external in source or internal.

The work that has been done with social feedback in complex human organizations has been general for the most part, largely theoretical (there has been little empirical research on organizational feedback) and oriented towards how things should proceed rather than how they do occur.[4] The designated variables have often been extremely high-order variables, like industrialization and pollution. The emphasis has been on cooperation within and between systems, to the almost complete

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[4]For a selected review of some of the theoretical work done on social feedback processes, see Appendix XIV. Reference to pertinent modeling of the hierarchy of goals will be made in Chapter IV.

exclusion of a consideration of the presence of conflict. This work so far has told us little about the varieties and characteristics of social feedback in the human organizations that are so much a part of our daily lives. In its general form this work can not illuminate the role that feedback plays in organizational regulation relative to other influences. The modeling that has been done, though non-linear in its conception, visually is perilously close to a portrayal of a chain of cause and effect relationships rather than acknowledging that you can't step into the same stream any number of times. Elements in a process don't wait for each other. To be precise, for the educational, political, economic, religious, family, and recreational organizations in which we interact we know very little specifically about the nature of the feedback processes that may be an integral part of their organizational direction, speed and implementation. Were we to decrease our ignorance, the knowledge would be important for organizational decision-making and planning (feed-forward) and for the accuracy of theoretical conceptualization and modeling for various types of organizations.

The task is a broad one. What are social feedback processes like? How do they effect goals and means establishment and implementation, re-establishment and re-implementation? Are there in fact systematic or even informal feedback processes? Are there differences between feedback in the various types of organizations or alternative feedback processes within the same type of organization? What elaborations or modifications should be made in existing models and concepts?

To begin, it would be wise to set some limitations that would make an investigation feasible and that would contribute to the probability of obtaining useful and enlightening information. Not all of

the questions one might have concerning social feedback could be satisfactorily answered in one study. And doubtlessly, the information from an initial study of feedback processes would suggest further studies.

Let us start by limiting the questions that are asked. As just mentioned, we have little specific knowledge of the nature of feedback processes and the characteristics of the feedback in any given type of organization. This suggests that the initial study must be exploratory and descriptive. We could ask the following descriptive questions that could be answered from data collected in a study with an exploratory, descriptive design:

Accepting the argument of cyberneticists that a goalseeking social organization is conceived and to some extent operates in terms of a social feedback model as an ideal type, what is the nature of the feedback processes that are in operation in_____? (a chosen type of organization).

It would likely be useful to break down the social feedback process into its component parts and pose a query about each part. Since we have a clear, general social feedback model, (see Figure 2.) let us use its feedback process breakdown. The component parts or activities are: 1. goal setting, 2. means setting, 3. feedback gethering, 4. feedback testing, and 5. corrective action. Taking these in order, the following specific descriptive questions emerge:

1. How are policies or goals established and re-established in_____? (the chosen organization).

2. How are means established and implemented, re-established

and re-implemented in_____? (the chosen organization).

3. What are the sources and characteristics of the feedback in operation in the social feedback processes in_____? (the chosen organization).

4. How is feedback assessed and evaluated in_____? (the chosen organization).

The fifth stage, corrective action, is included in the re-establishment of goals in #1., and the re-establishment and re-implementation of means in #2.

An exploratory, descriptive study can also address itself to theoretical, conceptual questions. We have a basic social feedback model. We do not know if certain changes in the model might be appropriate when this model is applied to a particular type of organization. Therefore we can ask the basic theoretical question:

Does the descriptive data from the_____(chosen organization) suggest elaborations or modifications of the basic social feedback model when applied to_____(the type of organization)?

Feedback models of all sorts are composed of greater or lesser numbers of stages. In general these stages are connected by arrows that indicate the direction of action. Visually they suggest, (some much more than others, as will be detailed later in the review of the literature) that the stages occur in sequence, the one effecting the other. However, it is very possible to conceive of the feedback process as being composed of several on-going, simultaneously operating processes. Keeping this in mind, the following specific theoretical question is

posed:

1. Within the social feedback system of the_____ (chosen organization), what is the relationship of time and the sequence of stages within the social feedback model?

The distribution of decision-making varies from one organization to the next. The "Control Center" may be composed of varying groups, not all of which are administrative, as presented by Buckley. If so, this would have direct implications on the social feedback model. And so a second specific theoretical question is posed:

2. Does the actual distribution of decision-making behavior in the_____(chosen organization) suggest elaborations or clarifications in the social feedback model when applied to_____ (the chosen type of organization)?

On the basis of these descriptive and theoretical questions we should be able to design an initial study of the specifics of organizational feedback. As was noted in the questions, the next limitation must be to restrict the field of study to one particular type of organization and to concentrate on gathering complete and detailed data about the feedback processes of that type of organization. Following this, further studies might be designed that would, for one thing, enable a comparison of feedback data between this type of organization and others. It is not far-fetched to speculate that, as organizations vary in formal structure, communication patterns, educational and experience requirements, organizational policies and goals, and so on, they also vary with respect to the types of feedback processes that operate within them. It is also possible that, within one particular type of organization, the

individual agencies might display significant feedback process differences. Consequently, in the process of conducting an initial study limited to one type of organization, one must be observant of both similarities and differences in the feedback within the agencies.

Across New Hampshire there are 13 private, non-profit mental health centers. Each center has its own citizens' Board of Directors, Executive Director, or chief administrator and hires its own staff. A catchment area has been assigned to each center, designating the population to be served, and indicating which center a potential client should be referred to. The general activities of the centers are coordinated by a continually revised Statement of Goals and Objectives (see Appendix I), established by the centers and the New Hampshire Division of Mental Health, and by a New Hampshire Community Mental Health Services Act, 1965 and 1969. A state Coordinator of Community Mental Health Service and Assistant Director of Mental Health for Community Services facilitate further coordination.

The mental health centers are funded by the State through the Division of Mental Health, through contracts with counties and towns, school systems and State agencies, through federal grants, patient fees (which are on a sliding scale, according to ability to pay), the United Way, donations and private trusts. The centers employ a number of types of professionals: psychologists, psychiatrists, social workers, counsellors, nurses, learning disabilities specialists, and other specialists within the field of human services. A secretarial staff and an administrative staff work with the social service professionals. The range of the size of the staffs in the New Hampshire centers is currently from 5 to 80. These staffs provide a variety of human services, among

them being psycho-diagnostic work, a range of therapeutic services, consultation services to many agencies, educational/training services to special target groups such as the mentally retarded, public education, community planning and organization, short-term inpatient services, and after care services for patients discharged from the one, centralized, State residential mental health facility.

Although being similar in general goals and organization and funding, the centers in New Hampshire are dissimilar at a number of points. One such dissimilarity is in size of staff. Another is centered about the number and range of services offered. Five centers plus a system composed of three northern centers are categorized as comprehensive mental health centers, which means, according to federal regulations and grant eligibility, that they provide limited-stay, in-patient services as well as out-patient services, day treatment to discharged mental hospital patients and others needing a therapeutic environment for several hours during the day, off-hours emergency services, and consultation and education to agencies and other groups in the community. Further, a comprehensive mental health facility must provide programs directed specifically towards children, youth, adults, the elderly, and people with drug and alcohol problems. Other New Hampshire centers, not classified as comprehensive mental health centers, provide a narrower, but sometimes more specialized range of services. Three of the centers are located in cities with a population over 30,000 but under 100,000. The others are located in smaller cities and towns that would be considered to be relatively more provincial. Over one half of the centers serve a population that is highly rural. In only a few of the center catchment areas is there any public transportation system. Some centers have

extensive linkages with other community agencies and resources, some are less extensively involved. Five centers have one or more branch offices. The others have none. Centers range in the length of time that they have been in operation from one year to twenty.

All of the centers are private, non-profit service organizations, relatively autonamous, though to be sure, strongly influenced by other groups. They are staffed largely by professionals with college and graduate school degrees, are ostensibly responsible to a citizens' Board of Directors and organized to meet the mental health needs of the community on preventative and rehabilitative levels.

From conversations with staff members and personnel in the Division of Mental Health this researcher was assured that the centers and Division were willing subjects for research on organizational feedback. They provide a convenient, moderately complex, though manageable, from the researcher's perspective, type of organization in which to search for greater descriptive and theoretical knowledge of social feedback processes.

With the mental health centers being the research subject the basic descriptive question reads:

Accepting the argument of cyberneticists that a goal-seeking social organization is conceived and to some extent operates in terms of a social feedback model or ideal type, what is the nature of the feedback processes that are in operation in New Hampshire mental health centers?

The basic theoretical question reads:

Does the descriptive data from the New Hampshire mental health

centers suggest elaborations or clarifications of the basic social feedback model when applied to mental health centers?

The words 'mental health centers of New Hampshire' would appear in the blanks of each of the specific research questions. To proceed with such a query should reveal information about the social feedback processes in mental health centers in one particular state. It should suggest a great deal about feedback processes in mental health centers in general, and other organizations with similar characteristics. It should establish a point of reference and comparison for further feedback studies. Such a study should also contribute to the conceptualization of feedback as process. It should reveal some things about the distribution of roles in the different stages of the feedback processes within an organization composed largely of highly educated professionals. The relationship regarding decision-making between Masters and Ph.D. or M.D. staff and their administrators in service organizations is probably more equalitarian or peer-like than the relationship of non-professional staff and their administrators in non-service organizations. In some instances the Ph.D./M.D. staff may have authority over their administrators. The turning point may not be so much years of education, but the field of education and the service/non-service organization variable. This study may, therefore, lead to suggestions for such modifications or elaborations of the social feedback model.

Models are no more and no less than tools to facilitate understanding. A detailed study of the social feedback processes in the mental health centers of New Hampshire should enable more accurate modeling of feedback in professional, service organizations. The model or models could detail what actually tends ot occur, not what should occur.

They could allow for variance in specific agency characteristics such as size and location, and for variables other than feedback that are significant in the goal-evolving process. One better model might lead to a better model yet.

To wit, the topic of the study, its necessity and uniqueness, the questions to be asked, and the specific field of investigation are now presented. A discussion of methodology, pre-testing and research problems, and limitations follows. We are venturing into the area of organizational control and communication to a depth not specifically researched previously. We are beginning with the assumption that goal-oriented social organizations operate to some extent by means of feedback. We are assuming that both the internal and external environments of organizations are continually changing, influencing their own systems' transformations as well as others. We are assuming that we can observe and comprehend processes and relate these impressions to others without trying to hold any action constant. We intend to conduct a systematic, careful study of social feedback processes with the intent of removing some of our lack of understanding and thereby providing certain insights that may be of use to organizations in the pursuit of goals that contribute to the greater well-being of the collective.

CHAPTER II

METHODOLOGY

A study of the social feedback processes in the mental health centers in New Hampshire, with the general objectives discussed in the Introduction, began in the winter of 1973-74. This researcher was reviewing some of the writings of Walter Buckley in which he presents the complexities one encounters when approaching organizational feedback, and realized that a systematic study on a modest scale was entirely feasible as a dissertation project.

Broad research questions were drawn up and a suitable organization to study (the mental health centers) was selected. Then came consideration of an appropriate, manageable research design. This study would of necessity be exploratory/descriptive. With so little specific work done on this topic, a study was needed that would expose the subject for further investigation. To collect accurate and complete data on feedback mechanisms and characteristics required a design that would corral information from all of the different groups in the research organization that are involved in the feedback processes. This undoubtedly meant receiving information directly from many individuals. To insure relative completeness of information and to reveal differences in perception, the study would have to include all the members of the involved groups. And to insure cooperation, the study would have to be designed in such a way that those involved had a certain investment in the study, a reason for participating, a return.

It seemed that the best way to accomplish this was to organize a study using the personal interview technique. This technique would

allow the researcher to explain the purpose and return of the study to everyone involved. It would practically insure data from all desired sources. It would give the researcher a high degree of control over the data gathering situation. And, since the study would be exploratory/ descriptive, would lend latitude in gathering information and probing for whatever might be there that was unanticipated.

The next question was, to whom and how should the interviews be applied? Information was obtained from the New Hampshire Division of Mental Health concerning the number and location of the mental health centers in the State. As a resident of New Hampshire, the researcher was familiar with many of the characteristics of the communities these centers serve. The Division provided useful particulars on the organization of the centers, their relationship to the Division of Mental Health, how long the centers have been established, and a considerable amount of other helpful background material.

With this information in mind, a sampling plan was formulated. There are 13 organized centers with a separate Board of Directors for each, in the State of New Hampshire. Branch centers are included under their central administration and Board. These centers are scattered throughout all the counties of the State. It was realized that many similarities and differences exist among the thirteen. As a rationale for sampling for a non-quantitative study, it was decided to match the centers along certain, apparently important variables, so that some characteristics would be constant for ease in comparing data from centers. At the same time, it was decided that other variables should be allowed to vary for a margin of divergence and to facilitate the tracing of possible relationships.

The variables to be held constant were: (1) category of center, that is, centers sampled had to be classified as comprehensive mental health centers. (This meant that they would have to offer similar services. See the Introduction.) and (2) length of time established. A sampled center had to have been in operation for at least five years so that some relatively stable patterns of activity would exist. Three variables were selected to differ. They were: (1) region of the state; the southern, more heavily populated, commercialized, trafficked and accessable in terms of transportation networks, as compared with the northern, relatively thinly populated, more economically depressed, more mountainous and less accessable transportation-wise, (2) type of community located in and served; the one center location being a major population and industrial center with an accompanying suburban catchment area, and the other being relatively small population centers with limited industrialization and a highly rural catchment area, and (3) size of center. Centers with more than 40 staff members were considered large. Those with less than 20, small. These were the two center sizes of interest. Medium sized were not considered. Northern, rural and small size were confounded, as were southern, urban and large size.

The reason that these particular variables were chosen was the intuitive feeling that there might well be differences in general communication patterns and feedback processes in a fairly large mental health organization located in an urban, highly industrialized, rapidly developing region as compared to a much smaller mental health center located inaccessibly far from large urban centers, serving a less prosperous, rural community with comparatively fewer options regarding most anything in life. And, in the face of these hypothesized relationships,

there was a need to provide some sort of base line for comparison. This was done by choosing to hold category of center and length of establishment constant.

Naturally, other characteristics could have been focused on to provide a basis for selecting a research sample, but in the absence of any better projections as to what the study might disclose, it was decided to make the committment to these variables.

With these in mind, the actual sample was drawn. The comprehensive mental health center chosen from the southern half of the state was the one in Manchester. It is located in the city proper, in a new, modern building on the grounds of the city's largest hospital. This center serves a busy metropolis of about 97,000 and an adjacent region of some 39,000 more.[1] Details of the center will be given in the presentation of the data on the Manchester Mental Health Center. Three small clinics in the northern part of the state were selected to fulfill that part of the sample. These three are located in: (1) Berlin, a small city of 15,100, serving a catchment population totaling 19,939. It is located north of the White Mountains, and is dominated by a single industry, the Brown Paper Company; (2) Littleton, another small city of 5,300 in the White Mountains serving a catchment area of 24,974; and (3) North Conway, a tourist center of some 5,680, also in the White Mountains. North Conway has a branch center in Wolfeboro, a tourist community of 3,141 located on Lake Winnipesaukee. Together the centers

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[1]These population figures and those that follow were taken from 1974 Resident Population Figures, Compiled by the Office of Comprehansive Planning.

serve a catchment area of 21,271. Each of these centers serves a surrounding catchment area that is roughly as large in area as Manchester's but is very sparcely populated, with folks sprinkled along a myriad of narrow, often unpaved roads. These northern centers form a comprehensive mental health system. They have coordinated their services to meet federal eligibility requirements, and collectively applied for and received a federal grant establishing the comprehensive system. None of these centers by itself was large enough in either total population served or services offered to become a separate comprehensive mental health center. Further details of their organization and location will be outlined in the presentation of the data.

Four centers and a branch center composed the sample for the research. In this initial study the researcher was to break some new ground, and it was felt that the detailed information from these centers would do just that. Exploratory studies do not prove anything. What they do is make it possible to ask further questions, better questions and make it possible to conduct other types of studies.

Consideration was given to the interview tool and how it could best be used to answer the research questions about the nature of organizational feedback processes. Interview schedules had to be designed that were appropriate for each of the groups involved with feedback in the research organization. The mental health organization in New Hampshire is composed of the following broad categories of employed or otherwise involved people: (1) administrative staff, which may or may not be completely distinguished from, (2) clinical staff (often the chief executive has been a clinician and continues to see a few clients), (3) clerical staff, (4) volunteers, (5) a Board of Directors, and (6) the

Division of Mental Health.

The decision was made to work up one interview schedule for (1) administrative staff, Board members and the people in the Division of Mental Health, and another for (2) clinical staff. Volunteers were excluded because they are a collection of people who come and go and have varied and often distant relationships with the rest of the organization. Clerical personnel were also excluded, but later included when their role in the feedback process was brought forth in the pre-testing of the schedules. Each schedule began with an explanation by the researcher of the objectives of the study. This was straight forward, but hopefully not in such detail as to suggest responses. The word feedback was defined as "information relating to goals". The introduction also included the hope of the researcher that the study could be seen as a type of exchange. For the opportunity to gather data in the centers the researcher would like to personally return to each center to present the findings of the study and discuss how they might be helpful to the organization.

Then, for the two interview schedules, tentative questions were drawn up. These questions were all open-ended. They concerned the role of the interviewee and others in the organization in each of the stages of the feedback process as presented in the model used by Buckley. The questions were limited to no more than thirteen in hopes of eliminating fatigue of interviewee and interviewer as well. Interviews were planned to last no longer than about twenty minutes.

Research data gathered by any method is only as good as the tool itself. It was therefore necessary to pre-test the interview schedules

before jumping into the actual data gathering for the New Hampshire study. So as not to contaminate the selected research sample, pre-testing was arranged at a mental health system in neighboring Maine, a state with a mental health organization similar to that in New Hampshire. Tri-County Mental Health Services, serving Oxford, Franklin and Androscoggin counties was the system. The In-Patient unit located in the Saint Mary's Hospital and the downtown Depot unit, both situated in Lewiston, kindly cooperated as the interview population.

Over a period of three days in May, 1974, interviews lasting between twenty and thirty minutes were conducted for the six-person team at the In-Patient unit, and a thirteen-person team at the Depot. In addition, the Executive Director for all units of Tri-County, the Administrative Assistant, and the Development Coordinator were interviewed, the later informally. The President of the Board of Directors was contacted and interviewed over the phone in August. Together, 23 interviews were conducted in the pre-testing process.

The first unit to be interviewed was the In-Patient service. Following that experience the interview schedule for clinical staff was revised. The In-Patient interviewing suggested that clerical staff should also be involved in the study. A tentative schedule was drawn up for this group and used with Depot interviewing. When the Depot staff and clerical personnel had been interviewed, further revisions in both schedules were made. At the time Tri-County administrators were interviewed, a decision had been made not to include interviews with staff in developmental services or the business department. The completed analysis of pre-testing data indicated, however, that individuals in such

positions are involved in the feedback process and should be included in a complete feedback study. Only one interview was held with a Board member, and that belatedly to obtain information for the report that was later sent to the Administrators and staff of Tri-County. None of the Advisory Board members at the Depot were interviewed. A complete feedback study, it was felt, should include at least two Executive Board members and two Advisory Board members. (For the New Hampshire study, none of the sample centers had Advisory Boards, though other centers in the State with several branch offices, do.)

The experience gained from the pre-testing was extremely useful. Certain questions included in the first interview schedules and the revised ones seemed to consistantly elicit clear, unambiguous, useful answers, and therefore were used for the final draft. Good examples of this are the first two questions on the clinical staff schedule. These ask the respondent to describe what people do on the service he or she is involved with, and to state the goals or objectives of this service. For the final draft, a second part to question number two was added which sought the manner in which goals were specified: verbally or in written form. This gave an indication of the degree of formality and referability of the goals. To the questions regarding who sets up the goals and means was added a probe about the role of the administrator, for it was found that his role was seldom mentioned. (That probe proved to be unnecessary for the New Hampshire study. Interviewees, without probing, offered that information. The role of the administrator had not been mentioned by pre-test interviewees because they either knew little of his role or, if they knew, saw it as a very distant, passive one.) It was observed from pre-testing that goals and means setters do not always agree and

that some degree of conflict is a continual part of decision-making. And so a question was inserted that asked what happens when goals and means setters do not agree.

The pre-test schedules ask the clinicians if they felt they knew what the effects of their service are? This seemed to make a couple of people defensive. Therefore, this question was put into a neutral form, but a form that still would give the researcher a feeling for how much reality testing these people felt they were getting on service impact. The revised question read:

Discovering the effects of a service can be very difficult. To what extent do you feel you know what the effects of the_____service are? short term_____actually not at all_____long term

_____to some extent _____

_____in large part _____

_____have complete knowledge_____

Two questions not on the pre-test schedules were added, for it was seen that this type of information would enhance the analysis by increasing the number of comparisons possible, and by enabling more precise description. The one sought to learn if the goals of the service were clearly enough defined that one could use them as a standard for comparing with the effects. The other appeared as a table. This table was developed from the inadequate and confusing pre-test question on the role of various groups at the center. On the table respondents were asked to list their feedback sources, and then to indicate whether they were oral, written, from observation, formal, informal, how frequent, inadequate for that clinician's purposes, adequate or an overload.

When the first pre-test interviews were made, clerical personnel were not included. An off-the-top-of-the-head schedule was formulated for clerical people along with the second group of interviewees. From this developed the clerical staff schedule for the New Hampshire study. It was noted from pre-testing that clerical staff act as a communications link. The final interview schedule sought to discover whether they also participate in center decision-making.

The schedule for administrators, Board members and Division of Mental Health personnel remained basically the same as the pre-test schedule. The first schedule asked what the role of these groups was. Since the researcher wanted to know what the role was with regards to goal-setting, means-setting, change, etc., these items were listed on the final schedule. The question was carefully introduced, so as not to make the respondent feel there were existing expectations on the part of the researcher about the respondent's role. In its final form the main question on this schedule read:

a. The various centers across the state delegate the many center responsibilities in different ways. Could you tell me what your role is, if any, at the center regarding: goal setting, means setting, execution of programs, feedback gethering, feedback communication, assessment and change.

b. What other groups, if any, play a role in the above?

c. What happens when goals-setters, means-setters, change-setters don't agree?

The pre-test interview schedules and the revised ones used in the dissertation data-gathering are to be found in Appendices II, III, IV, X, XI, and XII.

Pre-testing was useful in one other way. It enabled the researcher, with her committee, to firmly specify both general and specific descriptive and theoretical research questions. These are the sets of questions that appear in the Introduction, and are the basis of this study.

The way was then open for getting on with the study. During the months of August, September and October of 1974, this researcher set up appointments in the sample centers and with the people of the Division of Mental Health. The comparatively short traveling distance to Manchester and the scenic drives to the North Country were accomplished without difficulty. As explained earlier, one of the variables held constant in the study was comprehensiveness of the Center. To be consistant with this, only staff members that are primarily involved with services found in the other centers were interviewed. Further, staff whose primary function is working with the mentally and physically handicapped were not included. Staff in a separate drug drop-in center in Manchester were excluded. Three teachers and one individual in a program for clergy in Manchester also were not included as well as personnel in the Retired Senior Volunteer Program in Littleton. All in all, 13 interviews of administrators, clinical staff, clerical staff and Board members were conducted in Berlin, 18 in Littleton, 14 in North Conway and Wolfeboro, and 39 in Manchester. The timing of these interviews was fortunate for all concerned. It was at the end of the summer, when center appointments tend to be down somewhat. Other interviews were held just as school was beginning in the fall, before school and other agency personnel

had had a chance to pull together a great number of referrals. The interviews, therefore, took place in an atmosphere that was not too hectic, and that was one of very pleasant and helpful cooperation by all of those interviewed. In fact, this researcher was very graciously received. It was often her impression that interviewees were eager to express themselves about center processes. To many the study represented an anonymous, non-threatening forum for a range of ideas and feelings.

Interviews lasted between ten and 45 minutes. The shortest ones were with clerical personnel. The longest with persons who had a large number of feedback sources in the community. Only those people who worked halftime or more were interviewed. The feeling was that those few who work less than 2 days a week are likely to be somewhat peripheral to goals and means establishment and re-establishment, and are not regularly available in the communication processes of the center. For the same reason, consultants were not interviewed. In addition to the two interviews conducted with Board members from each center, the Boards were asked to have a sheet passed around to all members present at a Board meeting, on which they would list their sources of feedback about their center. This list could not be obtained from two Boards, not by refusal, but be forgetfulness by the Board.

The two key people in the Division of Mental Health involved with formulation of policy, setting and reviewing of goals and objectives for the mental health centers were interviewed for the study. They are the Assistant Director of Mental Health for Community Services and the Coordinator of Community Mental Health Services. Others in the Division concerned with the centers are two secretaries, an Administrative

Assistant (who provided much useful data), a Fiscal Administrator, and the Director himself. The Director has a representational, often political position. His responsibilities include the state psychiatric hospital, the centralized facility for the mentally retarded, all programs for the retarded as well as the mental health centers. His two next-in-line administrators were chosen for the study because of their day-to-day involvement with the mental health centers.

All of the center personnel in all of the groups included in this study were interviewed, with the exception of two who were unavailable during the interviewing period because of scheduling difficulties. This meant that almost all of the people involved in both the internal feedback system (feedback among organization members) and the external feedback system (feedback between organization members and others in the community) were included. Their perceptions, with their mutual agreements and some divergences, are represented.

The data collection completed, there remained the organization and analysis of the material. The next chapter in this study will detail the information that was gathered. The analysis of this information in the light of the research questions will comprise the fourth chapter. Conclusions and implications are the fifth. Before plunging into all the data collected, however, it is necessary to make the problems and limitations of the design clear.

The most obvious limitation concerns the size of the sample. With adequate financial and manpower assistance, this researcher would have liked to increase the size of the sample. Given its present size, the research implications are diminished. When data is gathered in a face-

to-face manner, the presence of the gatherer and the realization that information is being collected by the gatherer sets up expectations for the subject and forces that subject to become aware of things he might not have become aware of just then. The presence of a data gatherer changes a situation, including the desired information. For this study, it would have been preferable if the researcher could have unobtrusively gathered the data, eliminating researcher contamination. Such methods were, however, not feasible and/or unacceptable.

The nature of the primary research tool may also be considered a limitation. Certain unanticipated problems accrued in the process of gathering the data. First of all, though the researcher defined the word feedback for the interviewees, at least once and often more than once, it was not absolutely clear that all interviewees used the word to actually mean "information relating to goals". Some may have used it to refer to all information. Secondly, as soon as the word feedback was brought up, it suggested a concept that several apparently had not used in the context of their work. Some proceeded to use the word in answering the questions in such a manner that the researcher suspected she had set thoughts in motions. There is nothing wrong with that, unless the suggestion of the concept put pressure on the interviewees to find answers that weren't altogether there. One thing became clear: this study could never be replicated on the sample population, for the fact of running the interviews seemed to have an impact on the communication processes in the centers. Maybe it will only be redundant to bring the report back to the centers.

As to the questions on the schedules themselves: If the reader will look up the clinical staff interview schedule, Appendix IV, and read questions #5 and #9, he will note that alternative responses are listed. This was done to simplify the categorizing of the data. The trouble was that some interviewees felt they had difficulty answering those two, for knowledge of effects and discrepancy between goals and performance vary from client to client and from task to task.

Questions #14 and #15 had other difficulties. Most people interviewed did not realize that observation is a way of obtaining feedback, and so never indicated it. The researcher had the uneasy feeling that interviewees defined formal and informal in different ways. There was no guarantee that everyone remembered all of their sources of feedback, though the researcher tried to run through broad categories of sources corresponding to the major institutions, to help interviewees recall them. And the heading 'frequency' was decidedly problematic. For the most part, frequency of feedback from any one source depends on when a referral or contact occurs, and the nature of that contact. Feedback is often PRN or as needed, roughly. Enough information was obtained, however, to fit the heading into a perhaps more useful one, systematic or unsystematic feedback.

There may be other unseen problems with the interview schedules or parts of the research design, but these are the ones apparent to the researcher. What these mean to the study is that this researcher must be cautious in generalizing and drawing conclusions from the data. The reader, and potential further researcher on organizational feedback, must also keep these limitations in mind.

CHAPTER III

PRESENTATION OF THE DATA

INTRODUCTION

There are two basic questions on which this study was designed to throw some light. Six specific questions detail the inquiry. (See Introduction) The basic descriptive question asks the nature of the feedback processes that are in operation in the mental health centers in New Hampshire. The specific descriptive questions read: 1. How are policies or goals established and re-established in the mental health centers in New Hampshire? 2. How are means established and implemented, re-established and re-implemented in the mental health centers in New Hampshire? 3. What are the sources and characteristics of the feedback in operation in the social feedback processes in the mental health centers in New Hampshire? and 4. How is feedback assessed and evaluated in the mental health centers in New Hampshire?

The basic theoretical question asks if the descriptive data from the mental health centers suggests elaborations or modifications of the basic social feedback model when applied to this type of organization. The specific theoretical questions read: (numbering the specific questions consecutively) 5. Within the social feedback system of the mental health centers of New Hampshire, what is the relationship of time and the sequence of stages within the social feedback model? and 6. Does the actual distribution of decision-making behavior in the mental health centers of New Hampshire suggest elaborations or clarifications in the social feedback model when applied to mental health organizations?

As the data from the Manchester Mental Health Center and that from the centers in northern New Hampshire is presented, it will be done so according to the six specific questions, in their numerical order. The information directly related to each question will be detailed as presented by all of the interviewed groups. Following this some additional data, useful in the Analysis for explaining the feedback loops, will be included. The people served by the Manchester Center were referred to as patients by the staff, and are so referred to in this first data presentation. In the other centers in the study they were referred to as clients, and are so referred in the presentation of data from these centers.

A. Greater Manchester Community Mental Health Center

The largest center included in this study is the Greater Manchester Community Mental Health Center. This center was organized 13 years ago to serve the mental health needs of the people of Manchester and surrounding towns. The city is a busy commercial community along the Merrimack River. Like so many New Hampshire towns that developed along the rivers, Manchester is an old "mill" town and still displays an enormous complex of brick millyards and mill housing. These were built during the 19th century by the Amoskeag Corporation, so named after the falls at the upper end of the city, where Indians of by-gone centuries fished for Atlantic salmon, now disappeared from the river. The Amoskeag Corporation imported workers from many European countries and Canada to work in what were then the world's largest woolen mills and a thriving locomotive shop. Especially from that time on, Manchester has had a very heterogeneous population that clustered itself into numerous tight

ethnic communities of working class people.

The Manchester Mental Health Center was formerly located within the area of the millyard and Amoskeag Corporation employee housing. At the time of this study the Center had moved into a new, spacious and attractive facility about four miles up from the river. This facility was opened in July of 1973 and was made possible by federal grants for construction and staffing. The building was erected on the grounds of the city's largest and most modern hospital and is accessable to a network of major turnpikes that serve the suburban towns in the Center's catchment area.

As a comprehensive mental health organization the programs of the Center include a variety of outpatient services, consultation, education, 24-hour response, inpatient services and partial hospitalization. The latter two are both housed within the Center itself in its Inpatient and Day Hospital Unit. Patients may be admitted to the Unit for a short-term stay of generally no more than three weeks and frequently less. Day Hospital patients spend their days on the Unit and return home in the evening.

Thirty-nine interviews were conducted at the Manchester Center. Seven were of administrators, five of clerical personnel, 25 of clinical staff and two of Board members. Excluding Board members, interviewees had been employed for periods of time ranging from seven months to 13 1/2 years. Sixty-nine percent had been employed for less than two years, 31% for more than that amount of time. The data from these interviews was organized into administrative, clerical, clinical and Executive Board categories as it was compiled. Because of the large

number of clinical staff interviews and because of a clustering of attitudes, clinical staff data was divided into Inpatient, Outpatient and Night Shift categories. As the data is presented, these distinctions will be maintained.

QUESTION	RESPONSE
1. Goal Establishment	The seven person administrative team, composed of the Executive Director, the Medical Director, the Business Manager, the Director of Hospital Services, the Director of Community Services, the Chief Social Worker and the Clinical Supervisor of the Hospital Services, reported that they discuss organizational goals and policies within their administrative meetings, held three times a week. Patient goals are identified and reviewed with the clinical staff, individually or within the treatment teams. One administrator mentioned discussing organizational goals with the general staff. Only on seldom occasions were goals discussed with the Executive Board. (Generally, only the Executive Director and the Business Manager meet with the Board at their monthly meetings). Organizational goal and policy establishment and re-establishment are reported to be topics of frequent consideration by all administrators. Goal decisions are reportedly made in conjunction with staff input, though some organizational, especially financial decisions, are

made solely administratively. As the chief administrator, the Executive Director tries to give the department heads a general view of what the goals ought to be and work out the goals til all are in agreement. The Executive Director may participate in clinical goals setting through a limited amount of mental health worker supervision, an occasional patient and from being on call during non-office hours. If goal disagreement arises within the administrative group, the administrative staff reported four possible courses of action: the issue may be dropped, the problem may be more clearly identified but not solved, the Executive Director may make the decision, or everyone may compromise. The administrators concurred that efforts at agreement or compromise were always made. Democratic decisions were the ideal, and only in the minority of cases was an organizational decision made autocratically by the Executive Director, or a clinical decision autocratically handed down by the administrator of a unit. The Executive Director reported that he reserves the right for final decision, tries to steer arguments in the direction he feels correct, and only rarely overrules strong consensus by the other administrators. One administrator related that conflict was not a common part of the decision-making process. Another noted a distinction between goal setting by In-patient and Out-patient

staff: "In-patient staff are used to working things out on a daily basis. Out-patient staff are more isolated from one another, don't need each other, and are more likely to take strong, argumentative stands. Consensus is more likely when the two groups share a patient".

Clerical staff did not see themselves as involved with any clinical goal setting. They, and the administrators, did however, recognize the clerical staff's role in clerical and office routine goal setting and re-setting.

The Out-patient staff felt themselves fairly autonomous when clinical goal-setting and re-setting are involved. The prime therapist makes clinical goal decisions with either other team members or the program coordinators. Sometimes that therapist makes a one-person decision. A staff member noted that the administration decides when staff can't reach consensus. On organizational goals and policies the staff responses differed. Some reported these being set and changed jointly by staff and the administrative group; some said they were set by the Executive Director and the federal government; others felt that important decisions were handed down by the Administration or by the Executive Director. Instances of communications

confusion over goals were reported, some verbal battles, stalmates, postponements, conflicts, persuasions, compromises. One individual noted that ones educational degree pulls weight in a goal disagreement. Some decisions, another said, are made prior to staff conferences. There was a reported communications difficulty between Out-patient staff and the Administration. "The staff", remarked an interviewee, "try to work things out democratically, but democracy may not work. The Executive director makes unilateral decisions. The organization is very dependent on his nod."

The Night Shift agreed that they are not involved with either organizational or clinical goal setting. "We regulate people regarding eating and sleeping", but do not set or change goals.

In-patient staff perceived their role in goal setting as being much more important than did the Night Shift. For organizational goals the feeling of some was that all staff and Administrators decide together. Others saw themselves as having considerable input in such decisions. A few felt policies are set by the administration with some consultation of the staff. Treatment goals, they concurred, are worked out by the prime therapist, in teams, or in conjunction with the unit administra-

tors. Differences on clinical goals are deferred to the prime therapist, discussed out, fought over until either general agreement, compromise, or a majority position is established. Administrators may table discussions or decide certain issues, but seldom decide in opposition to the general view. Goal re-establishments on organizational matters were reported to be handled chiefly by the administration with staff input. Re-establishment of clinical goals fall to staff and administrators together. Program changes, related one, are worked out by the staff, then sanctioned by the administration. One noted that little conflict exists within the unit; another said administrators take a strong role.

The Board members feel that they decide for or against policy matters, organizational goals, new programs. Board committees work on specific matters, like personnel policy. The Board is not involved with clinical goals. They consider organizational changes, principally financial ones, but, because of their respect and trust of the Executive Director, rely on him for suggesting and making general changes. They do not, reported the interviewees, have major differences of opinion among themselves but do not always and automatically approve Executive Director and staff recommendations.

2. Means Establishment

The administrative group reported discussing and deciding on organizational means within their own group. In administrative meetings the Executive Director was identified as the mediatcr of the discussion, the strong, deciding voice. Some input into organizational means comes to the group from the staff in general staff meetings, though staff are more involved with clinical means. Staff discuss treatment means in teams, with other staff and with the program administrators, the latter often acting in an advisary capacity. Differences are worked out. At times administrators take the deciding role. The administrators noted that clerical staff have input into office procedures, and may on occasion, make changes themselves. The Executive Director explained that he delegates most of the responsibility for means and modification of means to the other administrators. All administrators, with the exception of the business manager, implement patient means decisions through their case load, consultation, supervision or prescribing medication.

The clerical staff concurred with the Administrator regarding their participatory role concerning the office routine and the keeping of statistics. One clerical person was in the process of moving into a combined clerical/administrative

position and so was involved in means setting with clinical staff.

Out-patient staff reported that organizational means are determined by the Executive Director with some staff input. General clinical means originate in the terms of grants received. They shift down from these through the Executive Director to his administrative staff and then down to the clinical staff. One Out-patient staff member remarked that there was pressure from the Administraion to use or not use certain therapeutic means. They want democracy, that person continued, but can't permit it in the end. Together, the responses of the group indicated that patient means are variously determined: sometimes by the prime therapist, sometimes as a contract between therapist and patient, sometimes by the therapist with administrative input, sometimes in teams or in peer review. The role of the chief administrator seemed to vary from one of leader, to moderator, to reinforcer, to decision maker or overrider. One staff member denied that disagreements on means occur. Another said that the administration dictates in cases of disagreement. Others saw the consequences of disagreements as compromise, stalemates with frustration, some double messages, and administrative decisions. One staff member explained that disagree-

ments are worked out when there is time for the process. Otherwise the Executive Director decides.

As with goal-setting, the Night Shift felt that they have no input into the establishment or re-establishment of means. They implement the goals and means decisions made by the prime therapist, the patient's team, the supervisors, the day staff or the doctor involved. One Night Shift staff member noted that the night charge nurse makes some changes affecting the night shift, and another revealed that certain changes in patient/staff interaction evolve.

The members of the In-patient staff gave the following responses concerning the setting of patient means: the prime therapist or team decides, the staff and administration decide, the patient's team and the entire staff decide, especially if the case is a difficult one, and sometimes an individual mental health worker decides. The unit administration was reported by one to play a consulting role. The Executive Director was reported by another as not playing any role in either goals or means setting for patients other than his own. Depending on the case or the staff involved, the following actions may occur in the case of means disagreement: the decision may be deferred to the person with the highest status, most experience, greatest ability to

persuade; the staff may work it out; the unit administrators may decide, especially if the matter raises a point of policy; or an individual mental health worker may decide after consultation. Sometimes various solutions are tried until one works. One staff member responded that there was no domination by the administration, though the unit administrators may act to clear decisions.

The Board members reported approving general means within a budget. They look for new sources of revenue and provide legal council for the center.

3. Feedback

The Administrative staff reported receiving the majority of their internal feedback from informal discussions with staff and fellow administrators. (Internal feedback refers to information relating to goals that has its source from within the mental health organization. External feedback, then, originates from persons or groups outside the organization). Internal feedback is received formally in administrative meetings and staff meetings. Internal feedback is both solicited and unsolicited. One administrator offered that more feedback is received from Out-patient than In-patient staff. This administrator felt that the closer proximity of Out-patient staff offices to those of the administrators was a significant explanatory factor. The admini-

strative group reported that the clerical staff perform an important role as communications links, passing feedback, on many subjects, from varied internal and external sources, back and forth between administrators and these sources. They are often the first line of contact with the Center. They transmit feedback both formally, as a part of office procedures and in meetings, and informally in casual situations. The Executive Director explained that he formally solicits feedback in an attempt to organize and simplify the information to be screened. He notices not having the direct contact he used to have when the Center was smaller. So as not to undermine department heads, he relies on channelled feedback. He notes a feedback and communication problem that reflects the lack of coordination in the entire staff. The sources of Administration feedback appear in Table I, Appendix V. It was explained that there is no policy or procedure established for following up on agency referrals or feedback.

The clerical staff explained that they receive feedback from staff, administrators, patients and their families, and from agencies and other external sources. This feedback is communicated directly to its appropriate receiver or through an intermediary, such as another clerical staff member

or clinical staff member. Some of the feedback is in the form of statistical data that is handled. A list of clerical staff feedback sources appears in Table II, Appendix V.

The sources and characteristics of the feedback received by Out-patient staff appears in Table III, and Table IV, Appendix V. In addition these staff members explained that feedback concerning clinical matters is obtained by observation, through bi or tri-weekly coffee groups with patients, through the monthly medical clinic, from statistics and records, through follow-up from subsequent therapists and by recidivism. One noted that there is no follow-up systems on patients. Another said follow-up depends on how much time a staff member has.

N.B. The Tables of Internal and External Feedback for clinical staff were filled out in the following manner. Each completed interview was assigned a letter of the alphabet. The identity of the interviewee was never recorded, and so these letters are purely arbitrary and cannot be traced to the staff member's name. For the Tables, the interviewee's letter was placed after each internal and external source of feedback he or she indicated. An X was placed for the reported characteristics of

that feedback. Two or three characteristics in any one range were often checked. For example, feedback from any one source, at various times might be, by his definition, inadequate for the staff member's purposes, adequate, or an overload, too much to handle and superfluous accumulations. Therefore, the X's in the columns and rows of the Tables cannot be counted and used for statistical calculations. The X's are not strictly comparable numerically. The numbers of X's must be viewed relatively. Any particular source may be largely oral or formal or whatever depending on the clustering of X's in the columns. It is interesting to note which characteristics are seldom or never associated with a source. Note the sources common to most interviewees and those directed to only one interviewee. If one follows the interviewee letters, one finds that some staff members have relatively few sources of feedback and are therefore very dependent on the others for precise and complete feedback. Some interviewers never judged a feedback source as inadequate. Few sources were accessed as offering an overload of information. The significance of the clusterings on these Tables will be discussed in the next chapter, Analysis.

The Night Shift staff explained that most of their feedback comes from shift meetings before and

after their on-duty hours, from observation, from calls from released patients, from progress notes, charts and files. Their limited internal and external sources appear in Appendix V, Tables V and VI.

Tables VII and VIII, Appendix V, contain the feedback tables for In-patient staff. Clinical feedback, they noted, is exchanged informally between staff, obtained by observation, from patients at discharge, through other services, some from Out-patient follow-up, Out-patient groups, and the follow-up medication program.

The Board members gave the following account of their feedback about the Center. One receives unsolicited feedback, but does not actively solicit it. Occasionally this person hears informal feedback from businessmen, but has no formal sources. The other reviews information from the New Hampshire Department of Mental Health, the National Institute of Mental Health, the United Way and from local psychiatrists, occasionally friends, seldom from politicians. The chief source of all information for the Executive Board is through the Executive Director and the Business Manager. Other administrative staff and clinical staff are seldom asked to attend Board meetings.

4. Evaluation and Assessment

Evaluation and assessment of goal attainment was reported by the Administrators to take place in administrative meetings, in peer review, during team meetings, supervision and with staff. They reported evaluation as a continual process with all Center groups, on both a formal and an informal level. The Executive Director explained that he tries to direct his department heads to work out methods of assessment and to report their assessment procedures to him. He feels he should receive reports from his administrative staff so that he can monitor Center activities and be satisfied that goals are being accomplished.

Clerical staff make assessments of the clerical routine, especially regarding efficiency. Certain clerical staff type up various reports of organizational and clinical goal attainment.

Out-patient staff emphasized that their full schedules have curtailed both formal and informal goal evaluations and assessments. Case conferences were scheduled to be re-instituted, but had been poorly attended in the past. The evaluations that occurred took place occasionally with other staff on an informal basis, with the Medical Director, in team meetings on rare occasions, with the New Hampshire Hospital team and with the new administra-

tive planning group. When asked if the goals of the service are clearly enough defined that they can be used as a standard for comparing with the effects, four staff members responded affirmatively, four negatively, one felt it is hard to judge the effects on the community, and another responded negatively for organizational goals but said "to some extent" for clinical goals. To the question of the amount of discrepancy between the goals of the Out-patient service and actual attainment, four indicated there was 'some', one said 'a lot', and the others said it is hard to know or varies from patient to patient.*

The Night Shift finds an opportunity to discuss the effects of treatment during the morning shift change meeting, informally among themselves, during one formal meeting a week with the administrators and sometimes with staff after work. One person felt that evaluations are seldom made during shift meetings. Two Night Shift staff members felt the goals of the services are not clearly enough defined to use them as standards of comparison, one said they are general enough to compare, and the other indicated being unsure, as their goals are not clearly organized yet. The discrepancy between

*See Appendix IV, Clinical Staff interview schedule, for the actual wording of these additional questions.

service goals and attainments was described as 'some' by three, and 'a lot' by one.

The opportunities to discuss treatment effects listed by the In-patient staff were: regular team meetings, daily staff conferences, frequent informal staff contacts, In-patient staff meetings without administrators, supervision and seminars. They responded to the clarity of service goals: five 'yes', one 'no', one 'to some extent' one 'not very clearly defined', one 'varies', and one said that "patient goals are sometimes not written and you don't know where you're at". The question of goal and attainment discrepancy brought answers: one 'none', seven 'some', one 'a lot'.

The Board members indicated that their role in assessing and evaluating goals is limited to budgetary considerations.

5. Time and Stage Sequence

The basic social feedback model that helps to form the basis for this study has five definite stages (see Introduction). These stages are connected by unidirectional arrows. Very clearly, feedback on an action can not occur prior to the action, nor can goals be evaluated before they are set. If one were able to follow the progress of any one goal that is established in an organization, one would see that certain actions could not logically proceed

other actions. One would also note that the length of time spent in any particular stage could vary tremendously with the organization, the issue, the complexity, conflict and a host of other variables. But the point that becomes clear from the data collected from the mental health centers of New Hampshire is that all of the stages seem to be in operation all the time regarding both organizational and clinical matters. At the Manchester Mental Health Center, administrators, clerical staff and all three groups of clinical staff reported considering goals and means establishment, evaluation and change on at least a weekly basis, and usually several times during the week. Patients come and go within short time spans on the In-patient unit, and their cases are discussed daily. These cases, and others, are referred to the Out-patient unit. Peer review teams regularly, though not always frequently, review all cases in Out-patient services that have been seen for a specified number of sessions, usually ten. Some clinical staff members pointed out that the general organizational goals do not change rapidly, but that therapeutic goals and means are continually in a process of transition. That is not to say that organizational policy and goals tend to remain relatively fixed, but, judging from the reports of the administrative staff, the process may

be protracted in time, and might sometimes be described as a process of evolution, rather than a series of definite decisions.

The Manchester Center, since the time of moving into the new facilities, has made significant changes and increases in programs, routines, staff, attitudes, organization, objectives. Many of these were in response to federal guidelines and requirements in legislation and the terms of funding. The list of changes noted by all staff is very lengthy. By the scope and scale of these changes, it is clear that the one decision does not necessarily wait for the other to run full term through the feedback process. On both organizational and clinical levels, the stages are in perpetual motion. Feedback is received from a multitude of sources on a continual basis. Certain decisions influence certain others. Certain decisions are not effectively communicated so their influence is lessened. Feedback may be more or less sensitively pick up and utilized. Changes in any particular goal or mean may occur because of variables other than and in the absence of feedback, like political events. None the less, the data from the interviews at the Manchester Center suggest that all stages of the social feedback model operate concurrently. The model implications of this will become clear in the next chapter.

6. Decision-making

In the interview schedule there are several questions that seek to discover which individuals or groups make the decisions on which types of issues. At a mental health center, the issues seem to be quite clearly divided into two categories, organizational/policy issues and clinical or therapeutic ones. Logically, decisions of the first type should strongly influence decisions of the second type. Policy decisions might be thought of as prior to and dominant over clinical decisions. In a traditional organization a chain of command operates to send down policy and organization decisions, while a top administrative group decides on the means. The majority of people in the organization are neither goals nor means setters or re-setters. What of the mental health centers in New Hampshire? The data from the Manchester Center is interesting in that it suggests that the traditional pyramid of decision-making does not apply, but at the same time the responses from the interviewees do not always concur. Some people who perceive themselves as decision-makers are not so perceived by others. More commonly, some staff feel that their role in the decision-making process is more influential than others do.

For policy matters, there was general concensus that staff has some input. Decisions are made either jointly by the administrative staff, by

the Executive Director with important influence from the other administrators, by majority rule of administrators with the final responsibility resting with the Executive Director, by Executive Director fiat, by the Executive Board with important administrative input, all of the above or some of the above. The more specific the policy or organizational issue, the less is the likelihood that the Executive Board will be involved and the greater is the likelihood that other staff, like clinical staff, will be importantly involved in the decision-making process. The Executive Director rated the influences of the clerical staff on matters of procedures as much greater than that staff rated themselves.

With clinical issues there were also conflicting reports. All did agree that the Executive Board is not involved. The question is one of the degree of autonomy and responsibility of the individual therapist. There was disagreement over who actively does make therapeutic decisions and who has the responsibility for them. The data indicates that in certain instances the decisions are individual or between the patient and the therapist. Sometimes they are joint among staff or between staff and administrators. Administrators have the power to overrule staff but do not frequently do so. The point of disagreement seems to come concerning cases

that are difficult or somehow controversial. The data suggests that sometimes the decision-making process continues until there is near concensus. If the luxury of time is not present, or the spirit of tolerance, respect and patience not present, the process may turn to majority rule, pressure tactics towards compromise or giving in, or administrative rule. It is to be noted, however, that the responses from the interviews did not suggest an enormous amount of conflict, though it was clearly present.

The decision-making process in the Manchester Center is not a simple one, and the many implications of this will be discussed in Chapter V.

The interview schedule used for clinical staff interviews contained questions designed to elicit supportive or explanatory data. The responses to three of these questions seem pertinent.*

1.a. The first of the three asked the staff member to relate the goals or objectives of the service he or she worked in. They were then asked if these goals were specified verbally and/or in written form. The responses were somewhat varied from the staff within each of the three clinical staff categories, but they were not contradictory. All of the responses were on the level of general goals. Some were more eloquent than others, some repeated what others had said, some added to. But it appeared that general goals had been well communicated and accepted. Only one Night Shift person said that they didn't discuss the goals.

*See Appendix IV.

b. How are the goals specified?

HOW GOALS ARE SPECIFIED

UNIT	TYPE OF GOAL	VERBALLY	WRITTEN
Out-patient	patient goals	xxxx	xxxxx
	general goals	xxx	xx
Night Shift In-patient unit	patient goals	xx	xxx
	general goals	x	x
Day Shift In-patient unit	patient goals	xxxxxxxx	xxxxxx
	general goals	xx	xx

N.B. As with the previous tables, the Xs cannot be counted and used as real numbers. They are indications of clusterings of responses. The same will be noted in the table below.

The second additional question of interest was worded as follows:

Discovering the effects of a service can be difficult. To what extent do you feel you know what the effects of your service are?

EXTENT OF KNOWLEDGE OF EFFECTS OF SERVICE

UNIT	DEGREE	SHORT TERM	LONG TERM
Out-patient	actually not at all		x
	to some extent	xxxxx	X
	in large part	xxxx	xxxxxxx
	have complete knowledge	x	x
Night Shift In-Patient Unit	actually not at all	x	
	to some extent	xxx	xxx
	in large part	x	
	have complete knowledge		
Day Shift In-Patient Unit	actually not at all		xxx
	to some extent	xxx	xxxxx
	in large part	xxxxxxx	xxxx
	have complete knowledge		

The final additional question to be reviewed asked the interviewees how the changes in staff on their unit or service during the last year had effected the service. This question was aimed at learning something about interruptions and effectiveness of feedback and decision-making.

A lot of responses emerged from this question. Selecting only material that might have some relevance, the Out-patient staff reported that they were busier, the changes had brought new programs, and that the ever-changing In-patient staff was demoralizing to Out-patient staff and made it difficult to relate to these continually new faces.

The Night Shift staff had been stable over the last year, but they reported the many changes in the Day Shift as being disruptive, bringing a lack of continuity and, distracting because so much time has to be spent training new people.

The Day Shift, In-patient staff had somewhat contradictory answers. Some said the staff had been pulled together and unified, with the help of two consultants. Others explained that some of these people have left and a new group will have to be formed. One said there was no disruption. Another said the changes have fragmented the service. New and older staff don't work well together. Another pointed to a lack of consistant leadership. Still another said the group is now open with each other. One dismayed at the time needed to orient new staff. Loss is difficult for all, said another.

B. North Country Community Services, Inc. Berlin, New Hampshire

One hundred and fifty years ago the population of the North Country of New Hampshire was considerably larger than it is today. Families journeyed inland from the coast seeking farm land. Though the land was often rocky and hilly, if not mountainous, early settlers transformed the North Country, and the rest of the state, into aridable land, reducing the forests to 15% of the state. Today, with 85% of New Hampshire forested, and the population clustered along the waterways, a walk through most any wooded area will reveal networks of stone walls built in the process of clearing land, and the cellar holes of families who left the land, in all likelihood, to seek a living in the urban areas.

The migration of New Hampshire's population from the country to the city occurred during the middle decades of the 19th century. Small New England farms could not compete with the agricultural, plantation south. But New England could use the advancing technology, the energy from her rivers and her railway system to develop an industrial economy.

The industrial city of Berlin is situated between Canada and the White Mountains and clings to the bank of the Androscoggin River. Logging has long been a major industry of the area. Not surprisingly, the mills that developed along this major river of the North utilized this natural resource. For the past 58 years the Brown Paper Company has been the dominant industry of Berlin and a very significant influence in the socio-economic development of the area.

North Country Community Services, Inc., is located in the midst

of Berlin, one block up the hill from the sprawling, sulphur exuding pulp mill. With the exception of the city itself, the catchment area is chiefly rural and sparsely populated. As the owners of the many wood-related industries do not have a history for being overly generous with their employees, the strongly French Canadian catchment population has never been especially prosperous.

There are many needs of the community to which North Country Community Services addresses itself. The organization has established the North Country Center for Exceptional Children, a program on alcohol and drug abuse, a sheltered workshop and a mental health clinic. The clinic is the segment of the organization this study was concerned with. A staff of eleven provides numerous out-patient services, emergency services, consultation and education, and has an in-patient arrangement with the area hospital which is located adjacent to their central facility. This facility houses the aforementioned services and is a reasonably roomy, not-unpleasant turn-of-the-century structure.

Thirteen interviews were conducted at the Berlin mental health clinic: Seven of clinical staff, three of clerical staff, two of Executive Board members, and an interview with the Executive Director. Not including the Board members, 55% of the interviewees had been employed for more than two years, 45% for less than that amount of time. Their length of employment ranged from six years to six months. The Director of Day Treatment, the Clinical Director and the Executive Director form the administrative group within the clinic. The Day Treatment and Clinical Director are also both involved with direct client services. At the time of the interviewing the Executive Director,

a Ph.D. in psychology, had recently given up his caseload so that he could spend full-time at administrative duties. Since the clinical staff is small, the Day Treatment and Clinical Director will be included in the presentation of clinical staff data. This becomes especially appropriate in the presentation of the feedback tables. However, their administrative role will be specified and their responsibilities in the decision-making process explained.

QUESTION	RESPONSE
1. Goal Establishment	The Executive Director explained that organizational goals and long-range planning are established and re-established with the planning program committee of the Executive Board. The Director meets regularly with his program directors to establish objectives and rationales for their programs. There is no real disagreement with the Board, he explained, and certain misunderstandings can be handled informally. The Director was afraid the lack of disagreement with the Board indicated a lack of involvement. For this reason the organization went to a corporate structure. The Executive Director continued that when disagreements arise with the program directors, they are good at cooperatively arguing the matter out. The Executive Director reserves the right at final judgment. The clerical staff when interviewed, reported a means-setting role, but not a goal-setting one.

The program directors and their staffs noted that organizational goals are variously set up and changed. Certain goals are established by the Executive Director and the program directors. Others involve staff input. Sometimes all clinicians determine goals during staff meetings. One interviewee said that general goals were articulated by the clinical director, but the source of these goals was unknown. Some goals "happen", said one, and another mentioned the influence of the Titlc III grant that unified the centers of Berlin, Littleton and North Conway into a comprehensive mental health system. Client goals may be worked out between the therapist and the client, by the program director, or jointly by the program director and the staff. When disagreements arise the group talks about the matter, sometimes persuades the others, may reach consensus but does not always change others' minds. In such cases the program director may decide. Those who disagree are expected to take the argument apart and pursue an alternative. One staff member said the group does not disagree.

Up until the time of the interview the Executive Board members reported that they had not been involved with goal setting.

2. Means Establishment

Means establishment and re-establishment are not as integral a part of the role of the Executive Director as formerly, he said. Means lie mostly on the shoulders of the program directors, though the Executive Director has the final say-so on means if he wants to use it. Clerical personnel, especially the Executive secretary, have input into office procedures.

From the clerical staff it was confirmed that they give suggestions on clerical organization and office procedures. One noted that she occasionally suggests clinical means.

The clinical staff related that client means are established either between the therapist and the client, or jointly by the therapist and the program director. One referred to means setting as a group process among all involved staff. In the case of a one-man program, that staff member decided on the means and their modification. Some decisions may be referred from the program director to the Executive Director for final decision. General goals, it was reported, involve discussions among the Executive Director, the program directors and the staff. A staff member said that budget matters go through the program directors to the Executive Director. Nine out of ten times, said one, what the staff proposes goes through. Sometimes the program director decides

after staff discussion. One major disagreement has occurred, according to one, and another explained that concensus was usually arrived at after a period of time.

The Board members reported that they had put together a Procedures and Personnel Manual. Generally, however, they approve means rather than develop them. They approve programs, act in an advisory and audit capacity, prepare budgets and check on expenditures. The Board acts on the recommendations of the entire staff regarding hiring. Though the clinical staff does not attend Board meetings, they do have input into major decisions. On points of disagreement, the majority rules following a careful discussion. In committee meetings, a serious issue is pursued until concensus is reached.

3. Feedback

The feedback sources for the Executive Director are to be found in Table XI, Appendix VI. He explained that he receives a great deal of informal feedback from the staff and his program directors. Every Monday morning there is a formal administrative meeting of the directors. Much feedback comes to him through the directors. This is done so as not to undercut channels of responsibility. The Executive Secretary reports organizational feedback to the Executive Director, as does

the bookkeeper.

Table XII, Appendix VI contains the feedback sources for the clerical staff. In a small city like Berlin, they hear many things on the streets from friends, acquaintances and clients. The clerical staff reported using discretion about reporting feedback. Only important comments relating to problems are reported. They pass feedback among staff members, here, too, exercising discretion. Time sheets and statistics are a part of their feedback communication within the agency.

The clinical staff listed the following opportunities for discovering the effects of treatment: informal meetings with general hospital staff, observation in the last therapy session with a client, calls from various outside sources, including the labor union in the Brown Paper Company and the Granite State Shoe Company, behavior modifications and verbalizations in therapy sessions and graphs on children in the schools. A complete list of staff feedback sources appears in Tables XIII and XIV, Appendix VI.

The feedback sources for the Board comprise Table XV, Appendix VI. One Board member noted that he doesn't know much about the clinic programs, and another reported receiving no feedback directly from

the staff.

4. Evaluation and Assessment

The Executive Director related that he plays an active role in evaluation and assessment. He monitors on-going programs with his program directors. He re-formulates organizational goals and will write in an evaluation component into all programs. The Board, he said, is not all that involved in assessment. Clerical staff are asked for input into office routine assessments.

The clerical staff concurred regarding their input into office routine assessments.

The following opportunities to discuss the effects of treatment were reported by the clinical staff: clinical staff meetings, supervision, frequent informal meetings with staff members or the Executive Director, in-service training sessions for the Northern New Hampshire Mental Health Systems, with the program director who shares his discussions with the Executive Director, following every morning Day Treatment session, weekly program meetings and group discussions of goal achievement. One staff member noted that evaluations are more frequently informal rather than formal. When asked if the goals of their service are clearly enough defined that they can be used as a standard for comparing with the effects, all staff responded affirmatively.

One added that Day Treatment goals are more precise than aftercare and another said there was too much non-direction. To the question of the amount of discrepancy between goals and actual accomplishment, one answered 'none', four 'some', one said the goals are general, another that there are some failures, but that most are helped to some extent, and another said one should ask the clients.

The Board members said they play no role in evaluation and assessment.

5. Time and Stage Sequence

The data collected from the Berlin center reinforces that collected from the Manchester Center. Goals and means setting, especially on the clinical level, are a continual process. Change is the norm. Feedback, especially informal feedback, acts as a constant potential monitor. The unification of the three northern mental health centers was funded just two years prior to the data collection, and in itself, had brought significant changes at all levels. All stages of the social feedback model seem to be operating concurrently at North Country Community Services, Inc.

6. Decision-making

As was noted from the data from the Manchester Center, decision-making at the Berlin clinic does not follow traditional bureaucratic channels. The Berlin clinic has relatively few staff members, and the distribution of tasks and responsibilities is not nearly as separated as is possible in a large clinic. Each staff member has many facets to his or her position. For example, the Executive Director listed the following activities that comprise his role: recruiting personnel, fund raising, business management, physical accounting, budgeting and budget monitoring, writing grants, monitoring disbursements and revenues, approving purchasing, program planning and development, public relations, coordination with the Executive Board and its committees with the Northern New Hampshire Management Council and with the Northern New Hampshire Mental Health System, the later two being the advisory coordinating bodies for the comprehensive mental health system that is the recipient of the federal grant the three clinics share. At a larger center one would find a business manager involved with several of the above-mentioned tasks, and a sizeable administrative group sharing certain other responsibilities. In Berlin, the administrative group at the time of interviewing was composed of three persons. The program directors in that group

were very active with their clinical responsibilities. Policy and organizational decisions seemed to be made chiefly by the Executive Director with administrative input, with Executive Board sanction, or jointly by the three-man Administration. As all staff members are in close contact with one another, clinical staff also have input into organizational decisions. On clinical matters, the data brings out a strong emphasis on collectiveness. There seems to be a minimum of pulling of rank, and also a minimum of involvement by the Executive Director in individual clinical cases. The Control Group for organizational issues includes the Executive Director, the Executive Board, and the two program directors. The Control Group for clinical issues is composed of the program directors and their staffs. The implications of this and of the timing of feedback stages will be discussed in Chapter IV.

The interviewees at the Berlin clinic gave the following responses to the three supplementary questions:

1.a. What are the goals/objectives of the center or your service? The clinical staff did not indicate any significant differences in their understanding of the general goals and objectives of the services.

b. How are they specified?

HOW GOALS ARE SPECIFIED

TYPE OF GOAL	VERBALLY	WRITTEN
client goals	xxxx	xxxxx
general goals	xxxx	xx

2. The clinical staff indicated the following extent of knowledge of effects of service:

EXTENT OF KNOWLEDGE OF EFFECTS OF SERVICE

DEGREE	SHORT TERM	LONG TERM
actually not at all		
to some extent	x	xx
in large part	x	
have complete knowledge		
varies for long term		xx
doesn't know for long term		x

3. The clinical staff explained the effects of the many changes at the center in the last year as being advantageous, stimulating, constructive without representing an interruption of services. Staff case loads are smaller, the services are expanded, and informal consultations have been stimulated. A re-alignment of staff relationships has occurred. With expansion has come a renewal of communication and greater systemization with increased autonomy.

C. White Mountains Community Services, Inc., Littleton, New Hampshire

As one journies through New Hampshire's White Mountains, past the stone profile of the Old Man in the Mountain, beneath skiing and hiking mountains that flank ancient U-shaped glacial scoured valleys, one comes upon small, somewhat isolated towns and communities. The

towns are generally arranged along an assortment of rivers whose head-waters lie high in the unpopulated mountains, or far back in several dozen unincorporated territories and grants. The base of the economy of these towns and cities lies principally in tourism and small mill industry. This is the case with the city of Littleton.

Littleton nestles beneath the shadows of the Presidential range, just far enough north to avoid the scourges of the severe weather associated with that range. The Ammonoosuc River speeds through the center of town by a mill of modest reputation, the Saranac Leather Company. Up the hill a short distance lies the White Mountain Community Service. This mental health center is situated in a pleasant, though somewhat crowded white frame building on the grounds of the community hospital, with which there is an arrangement for in-patient services. The Center was established ten years ago to serve a catchment area of 22 towns that carry interesting names like Sugar Hill, Bethlehem, Woodstock and Bath.

As with the other mental health centers in this study, the Littleton center offers a variety of out-patient services, consultation services, education services, day treatment, in-patient and emergency services. In addition the center administers a Children's Development Center for the retarded, and the Work Activities Center for the handicapped. At the time of interviewing, a clinical staff of nine, a clerical staff of five and two administrators provided the mental health services at the central facility and in several of the catchment area towns. Of the 16 total staff, whose years of employment ranged from one month to seven years, 38% had been employed longer than two years. Sixty-two percent had been employed for less than that amount of time.

Below is the data collected from this center. It should be noted that the Executive Director had been with the center for only two months at the time he was interviewed. He, therefore, had little experience at White Mountains Community Services from which to speak. When the staff reported on decision-making they referred to the way matters had been handled under the former Executive Director, and did not seem to be anticipating major changes in these processes.

QUESTION	RESPONSE
1. Goal Establishment	The two-person administrative team reported that they are involved chiefly with organizational, policy and procedural goal-setting. The Executive Director indicated being involved with clinical goals to some extent. Organizational and policy goals are arrived at through discussions involving all staff; clinical, clerical and administrative. When the goal-setting group does not agree, attempts are made to reconcile differences. If this becomes impossible, the Executive Director decides. The clerical staff explained that their role in goal-setting was limited to office matters, and that these decisions were made with the Administrative Assistant. Clinical staff answered that general, organizational goals are set by the Division of Mental Health, the Executive Board, are written in

the charter, and are set by the Administration with considerable staff participation. Client goals are established by the therapist with some staff input at staffings, by the program director, in conjunction with the administration or with the therapist's supervisor. A program director may establish certain goals with other agencies. The psychiatrist has latitude to establish some goals, such as the emergency service policies. One staff member emphasized that the goal-setting at the center was a highly democratic process. In the case of disagreement, the Executive Director casts the tie-breaking vote. "Staff define the issues and the administration interfaces with the Executive Board", noted one. The former Executive Director had an equal vote with the clinical staff though his was the ultimate responsibility, noted another. Consensus, it was reported, is generally arrived at, but a vote is taken on debated issues. Changes are initiated by the clinical staff. The therapeutic changes may be directly implemented by the staff. Other changes channel to the Executive Director and then on to the Board. On matters of change, the entire staff has been known to argue, discuss and compromise. "Some profound disagreements have resulted in some sound compromises", offered a staff member. Another said disagreements over changes don't occur.

The Executive Board members noted that goal setting usually begins with suggestions or initiative from the center's staff and Executive Director. Usually the Program and Planning Committee agrees with the staff and passes along their recommendations to the full Board. "The Board has the power and interprets to the community". The president of the Board can influence but not dictate decisions. Changes in policy come from the Program and Planning Committee upon the recommendation of the Executive Director and go to the full Board for approval.

2. Means Establishment

The means setting role of the administration, by their account, is focused chiefly on organizational means. The Executive Director has some input into clinical means, but those decisions, said he, are mainly made by the clinical staff.

The clerical staff participate with the Administrative Assistant and other staff in setting and changing office procedures. This is accomplished through weekly meetings with the Administrative Assistant and informally with this person.

The clinical staff reported that they are involved with the Executive Board in establishing and re-establishing general means. Clinical means may be set by the client's therapist with some staff input, by the program coordinator with staff input, by

the staff with influences from the Northern New Hampshire Mental Health System or by the staff and the Executive Director. The psychiatrists at the center make therapeutic decisions for the general hospital physicians, with input from the administration.

Under the former Executive Director, disagreements were continued until consensus was reached, explained a staff member. Another felt that disagreements didn't occur. Several noted that issues of diverse opinions are talked out, and that the Executive Director has the final decision. One said that there was a lot of trust between the administration and the staff, and that staff had a great deal of autonomy. Another noted that the administration and the staff work out disagreements on an equal standing. The same pertains to decisions concerning changes.

The members of the Executive Board reported that all means must have Board approval. What this means in practice is that general means are established by the Board, including the financial means which originate with the Executive Director's budget, go through the Finance Committee and then to the full Board for approval. Means for specific (clinical) goals are set by the Director and the staff. The Board President may attend staff meetings and

influence important decisions if necessary. One board member explained that the center has only had two Executive Directors in its history and both of these individuals have fit the Board's image of what they wanted for a Director. Because of this, the Board has always been able to reach agreement through thoughtful discussion at all levels. The Board would have final say should an impasse arise.

3. Feedback

The feedback sources for the Administration are listed in Table XVI, Appendix VII. The Executive Director noted that he solicits both oral and written feedback from the staff. Because of his short employment at the center, his external feedback sources were somewhat limited. He explained that he used formal center meetings to communicate feedback.

The clerical staff in Littleton act to pass along feedback between staff members, between the Executive Board and the Administrators and staff, especially if the Board members are personal friends. One clerical staff member reported using discretion when passing along informal feedback. Feedback on clients may be passed on to the clinicians. A list of clerical staff feedback sources appears in Table XVII, Appendix VII.

The complete list of clinical staff feedback sources appears in Tables XVIII and XIX,

Appendix VII. Staff members noted that sometimes telephone feedback is received from clients, or follow-up letters are sent out to clients, but that there was no systematic follow-up system. A questionnaire research project was undertaken, seeking a success rating from clients to be compared with the therapist's own rating. These questionnaires were returned mainly by satisfied clients and the study was abandoned. One noted that telephone follow-up is more successful than questionnaires, while another felt that client feedback is entirely anacdotal.

Table XX, Appendix VII, contains the list of Executive Board feedback sources. The members explained that there is no systematic feedback gathering or communication undertaken by the Board. However, complimentary letters received by one member are read to the Board and passed to the Executive Director, and oral feedback is exchanged at Board meetings.

4. Evaluation and Assessment

The Administration reported being chiefly involved with organizational and policy assessments and evaluations. One explained that this is often done informally. Assessments from others are gathered and then decisions are made as to where and how to proceed.

Clerical staff reported making assessments only about those issues that involve office procedures.

The following opportunities to discuss service effects were listed by the clinical staff: monthly staff and administration planning meetings, weekly staffings, supervision, a great deal of informal discussion, program meetings, and joint therapy sessions. One indicated that adequate time for such evaluations was found.

When asked if the goals of the service are clearly enough defined to be used as a standard for comparing with the effects, four answered 'yes', one specified 'yes' for in-patient and partial hospitalization but 'no' for emergency and out-patient services, one answered 'no', another 'varies from yes to no', and two others felt they didn't know.

To the question of the amount of discrepancy between goals and actual accomplishment, the clinical staff responded: two 'very little', three 'some', two 'a lot', one 'varies'. These responses came from clinicians with varying levels of expectations for their clients. Those who set attainable goals for their clients were more apt to see little discrepancy between goals and attainment. Those who aimed at bringing the clients into a relatively permanent state of ability to function successfully in the community, responded differently. One clinician added that goals are loosely defined. Another noted that "specific goals keep changing".

One Board member admitted that the Executive Board has no adequate means of assessment, and that they don't know what to measure. The second Board member pointed out that effectiveness of services is the bailiwick of the staff. Staff evaluations are done by the Executive Director. At the time of interview the Board was setting up a process to evaluate the Executive Director.

5. Time and Stage Sequence

Data collected from White Mountains Community Services further re-confirmed the findings from both the Manchester and the Berlin centers. (See Presentation of the Data, Section A.). The process of establishing, evaluating, modifying, changing goals and means at all levels is a continuous one. This process appears to be influenced by a fairly regular, albiet unsystematic and tremendously varied network of feedback. However, the decision-making process does not need to be seen as strictly dependent upon the flow of feedback. This will be more explicitly detailed in the presentation of alternative models in Chapter IV.

6. Decision-making

After taking a close look at the data collected from the third mental health center, it becomes clear that the traditional bureaucratic pattern of decision-making does not apply in the organization under study. Previous data has suggested that clinical, and to a limited extent,

clerical staff, are very influential in the process of establishing clinical goals and means. They have important input into organizational decisions. The Littleton data puts together a picture of a community of administrative, clinical and clerical staff pooling their resources in a fairly equal fashion to decide on both organizational and therapeutic matters. Ultimate responsibility is still vested, as in the other centers, with the Executive Board and the Executive Director. But the Control Center is a highly democratic body composed of all staff.

The Littleton staff gave the following responses to the three additional questions entered as explanatory probes:

1.a. What are the goals/objectives of the center or your service? The responses were more numerous and diverse than was observed in the other centers. And, as was seen in Sections A and B, no contradictions appeared, indicating a high degree of communication, consensus, internalization of general goals and objectives.

1.b. How are they specified?

HOW GOALS ARE SPECIFIED

TYPE OF GOAL	VERBALLY	WRITTEN
client goals	xxxxxx	x
general goals	x	xxx

One noted that goals at all levels are continually updated.

2. To what extent do you feel you know what the effects of your service are?

EXTENT OF KNOWLEDGE OF EFFECTS OF SERVICE

DEGREE	SHORT TERM	LONG TERM
actually not at all		
to some extent		xx
in large part	xxxxx	xx
have complete knowledge		

One added that it is hard to find out. Another did not know. A third and fourth reported they felt that the extent of knowledge of effects varies with the service or program.

3. How have the changes in staff during the past year affected the services? The staff noted that: changes mess up the on-call schedule, bring up-tightness among staff resulting in less objectivity, result in fatigue and strain among staff since there is a policy of no waiting list, make the staff less affective, require a great energy expenditure on the part of old staff to train new staff, has brought a broadening to the staff, a few communication problems and has left staff morale a little tattered.

The implications of these responses, as far as they can be drawn, will appear in the next chapter.

D. Carroll County Mental Health Services

North Conway and Wolfeboro, New Hampshire

In the nineteenth century it was very popular for the more prosperous dwellers of New England's cities to journey by train up into New Hampshire's lakes and mountain regions to spend a period of summer

weeks at the large, sprawling hotels that were being built there. Fashionable tourists frequently chose the Intervale area and North Conway, just below the Mount Washington Valley, to spend leisurely days of croquet, walking, scenery gazing, fresh air inhaling and hiking for the most adventurous. Others chose to recreate beside New Hampshire's largest lake, Lake Winnipesaukee, and reside in charming Wolfeboro, perhaps to enjoy a ride on the sight-seeing paddle-wheeler.

Those were summers far removed from the stern lives of the Passaconway Indians who had resided in the Conway-North Conway area, and equally far-removed from the adventures of General Wolfe of French and Indian War fame, after whom Wolfeboro derives its name. They were days of a leisurely pace with plenty of time, for the tourists at any rate. Today, North Conway and Wolfeboro are still centers of tourism, both in the summer and the winter. But the pace of today's recreation bears scant resemblance to that of pre-automobile days, pre- aero-space days, pre-electronic media days. For tourist and resident alike, though the human scenarios may be the same, the non-human environment sets the stage of another world.

Today's world has a set of realities all its own. The staff at Carroll County Mental Health Services have been helping people within the county deal with these realities for 6 years. A staff of 12 work out of a central office in the midst of North Conway's shops, restaurants, and not-so-sprawling motels and inns. A compliment of out-patient, emergency, consultation and in-patient services are directed from cramped, second floor offices in an interesting old professional building. Four of these staff members spend much of the week working out of a suite of offices in the general hospital in Wolfeboro, where an arrangement has

been worked out for in-patient services. Certain in-patient services are also provided in the general hospital of North Conway. When interviewing was conducted the range of the length of employment of all staff was between two months and two years. Eleven of the 12 staff members or 92% had been employed for less than two years. Sixty-seven percent had been employed for less than one year.

Below is the data collected from the staff of Carroll County Mental Health Services.

QUESTION	RESPONSE
1. Goal Establishment	The Executive Director, who previously held the position of Executive Director of the Northern New Hampshire Mental Health System, reported that his role includes administrative and some clinical goal setting. He works with the clinical staff, the clerical staff, and the Executive Board to set goals and priorities. In the case of disagreements discussion to bring about persuasion is used. Though agreement is the rule, the Director explained that he would exert pressure if he strongly disagreed with the staff. Final goal decisions are up to the Director. On a System level, the Executive Director is involved with the other two executive directors and three representatives from each executive board in a group called the Northern New Hampshire Mental Health System Management Council. This group sets over-all goals, programs, structures and coordinates the System's needs with the requirements of the

federal grant that initially funded the System. The Carroll County Executive Director reported that there exists an unclear hierarchy of goal setting and area autonomy and responsibility within the Northern New Hampshire Mental Health System.

The clerical staff related that their role in goal establishment is limited to goals directly involved with their jobs. Clerical staff sit in on staff and general meetings in North Conway and Wolfeboro, but their role is unclear.

The clinical staff listed the following ways that general goals may be established: by the terms of the federal grant, through hazy guidelines from the State, jointly by the staff and the program director or by delegation of responsibility to one particular individual. The ultimate decisions on matters of organizational policy lie with the Executive Director, it was explained. The Executive Director has helped out with setting client goals, but, noted one staff member, since the Director is not a clinician, the therapists are pretty much independent. Client goals are generally established by the therapist with the client or by the medical director and the full staff jointly. One staff member related that program goals are established and re-established by the program director, the medical director and the Executive Director in

conjunction with staff input. Concerning disagreements, one felt that there were none about goals. Another said the staff discuss these disagreements and try to work them out. A strong opinion may convince the others said one. Long discussions, (emphasizing long) were reported to bring about resolution or consensus. Compromises are sometimes made, and additional information and consultation may be sought to facilitate the decision-making process. Changes in client goals are made by the therapists, individually or collectively. The program director and Executive Director give final approval. Organizational changes involve staff input, but are made by the Executive Director with the program and medical directors. The director of the Wolfeboro unit makes the decisions on changes it was reported. Several noted that all types of goals are continually being altered.

The members of the Executive Board explained that the Board establishes, reviews, and re-establishes organizational goals and priorities. These decisions are arrived at with input from staff professionals. There is a regular process of review and change of these organizational goals. Board members do not set clinical goals. At points of disagreement, the majority rules on a motion. The administration provides information and opinions, but does not have a vote. One Board member who was also on the

Management Council, explained that when that body can't agree on broad goals, the matter is referred to a board of the entire System. If it should happen that that body would not agree, theoretically they would disband. But, he added, the members of these boards can agree to disagree.

2. Means Establishment

Means of all types, reported the Executive Director, are established and re-established jointly by all staff during in-service training sessions and at staff meetings. The Director has final say on the re-establishment of organizational means and on program changes.

The clerical staff said that their role in means setting is limited to participation in decisions about office procedures. One clerical staff member discusses office matters once a week with the director of the Wolfeboro unit.

The clinical staff concurred that administrative means are the responsibility of the Executive Director. "We respect his expertise", said one. Therapeutic means may be set and changed by the therapist and the supervisor or jointly in weekly staff meetings. The medical director has responsibility for medical decisions like medication. One staff member noted that therapeutic decisions are team decisions. Disagreements over therapeutic means bring about discussions, compromises and final

resolution. One remarked that decisions concerning changes in therapeutic means may involve the client himself. Another said that disagreements over therapeutic changes haven't come up.

The members of the Executive Board reported that they listen to the staff and the Executive Director and try to get funding to implement their programs. The Board studies proposed means and approves or modifies them.

3. Feedback

The Executive Director reported that he both elicits feedback and receives unsolicited feedback. This information he passes on to the staff and the Board. A list of the Director's feedback sources appears in Table XXI, Appendix VIII.

Clerical staff act as a communication link in the feedback process. They receive feedback over the telephone and relay the information from clients and their families to the clinical staff. They make decisions as to where to direct the information. As do all clerical staff in the mental health center, this clerical staff prepares and sends statistics to the Division of Mental Health. A list of clerical staff feedback sources appears in Table XXII, Appendix VIII.

The complete list of feedback sources for the clinical staff appears in Tables XXIII and XXIV Appendix VIII. The staff noted that there is no follow-up system for clients, but that some informal follow-up sessions take place. Some staff members keep in touch with identified referral sources. Previous clients are observed in the community by the staff. Day treatment and aftercare staff keep in touch with certain long term clients. Reports from subsequent therapists and statistical analyses were also listed as ways clinical staff find out about the effects of their services.

The members of the Executive Board explained that they both elicit feedback and receive unsolicited feedback. One member said that he tries to be sensitive to how the community at large receives the services. Feedback is exchanged among Board members at Board meetings, at committee meetings and with the Executive Director. Table XXV, Appendix VIII contains Executive Board feedback sources.

4. Evaluation and Assessment

The Executive Director related that he makes assessments of program objectives. The clerical and clinical staff, he noted, participate in assessments related to their activities.

The clerical staff explained that they make suggestions and assessments on clerical issues, such

as intake procedures. One prepares a report on proposed changes of office procedures.

Clinical staff members listed the following opportunities for discussing the effects of their services: one or two formal meetings a week, daily informal discussion, program meetings, supervision sessions, monthly in-service training sessions and social encounters among staff after work hours.

When asked if the goals of their services were clearly enough defined that they can be used as a standard for comparing with the effects, three answered affirmatively, two negatively, two 'yes for client goals', two 'no for general goals', and one said that the goals are not operationally defined.

Clinical staff responded to the question of the amount of discrepancy between goals and actual accomplishment as follows: four 'none', two 'some' and one in between 'some' and 'a lot'. One felt that the results tend to be better than the goals.

Assessments are undertaken mainly by the Executive Director, offered one Board member. The other expressed the opinion that assessments are made insufficiently by the Board. He will push for a better assessment procedure at the local and Systems level.

5. Time and Stage Sequence

The data gathered from the Carroll County Mental Health center offered no surprises, but only reinforced that gathered from the other centers concerning the relation of time and the sequence of stages in the social feedback model. To avoid repetition, see Section A of this chapter and the analysis that follows.

6. Decision-making

The examination of the decision-making process at all the centers in this study clearly demonstrates that a model for organizational decision-making other than the traditional one must be used for mental health agencies in New Hampshire. The process at North Conway is more similar to that in Littleton than to that in Manchester and Berlin. This is to say that decisions tend to be highly democratic, jointly arrived at ones, involving all or most staff. The centers at Manchester and Berlin have a more complex delegation of roles for the various types of decisions and a more clearly drawn hierarchy. They also have the largest administrative staffs of the four centers.

For this fourth center we also turn to the three additional explanatory probe questions asked of the clinical staff.

1.a. What are the goals/objectives of the services? As with the interviews from the other centers, the answers were varied, though

consistent with one another and were not contradictory.

b. How are they specified?

HOW GOALS ARE SPECIFIED

TYPE OF GOAL	VERBALLY	WRITTEN
Client	xxxxxxx	xxxxx
General	xx	xxxxx

2. To what extent do you feel you know what the effects of your service are?

EXTENT OF KNOWLEDGE OF EFFECTS OF SERVICE

DEGREE	SHORT TERM	LONG TERM
actually not at all		x
to some extent	x	xx
in large part	xxxxx	xx
have complete knowledge		x

One added that it varies through the entire range.

3. How have the changes in staff during the past year affected the services? The interviewees mentioned problems with continuity of service because of the clinical staff and the administrative change, but did not mention the consequences to the communication process.

The Frequency of Feedback

In Chapter III it was noted that the question on the frequency of the sources of feedback turned out to be somewhat problematic. Interviewees could not give responses to frequency of feedback, for the frequency tended

to vary. In practically no instances, in any of the four sampled centers, were the interviewees able to say that they received feedback from a particular external source at certain designated intervals, for none of the centers have established a formalized external feedback system. A few staff members have set up a fairly regular communications link with other agencies or important feedback persons, such as former clients, but the vast amount of external feedback is either solicited or received without solicitation on the basis of, as needed, or as happens to come in. It would appear that the agencies with which the centers are involved do not have regular external feedback systems either. Therefore, it is apparent that the external feedback in the mental health centers is unsystematic.

All centers schedule regular and frequent meetings among all staff and with the Executive Board and the Division of Mental Health. In these meetings, by their reports, feedback is communicated. And so the internal feedback of the mental health centers may be termed systematic.

E. New Hampshire Division of Mental Health
Community Mental Health Services, Concord, New Hampshire

The offices for the New Hampshire Division of Mental Health, Community Mental Health Services, are located in a comfortable office building on the grounds of New Hampshire Hospital, the State's centralized, residential mental health hospital. The address, Pleasant Street, was once Asylum Street. The change may be more gracious than honest.

As detailed earlier, the Office of Community Mental Health, one of four components of the Division of Mental Health, is administered by

an Assistant Director of Mental Health for Community Services, a Coordinator for Community Mental Health Services, an Administrative Assistant, a Fiscal Administrator and a secretarial staff. In its introductory pamphlet, the Office of Community Mental Health explains that it "is responsible for assisting communities in assessing mental health needs, planning, developing, operating mental health services, and allocating state funds to community organizations under the provisions of RSA 121B-New Hampshire's Community Mental Health Act".

The Office of Community Mental Health works with the administrators of the mental health centers to review the Statement of Goals and Objectives, work with the Standards of Eligibility for State Grants-in-Aid, and establish the Standards for Community Mental Health Services. Further, the Office assists with planning and program development, acts as a liaison with the state legislature and with federal agencies, facilitates and monitors community mental health programs, provides fiscal and statistical consultation and monitoring, and offers administrative and technical services to the mental health agencies. A complete list of the functions, goals and objectives of the Office appear in Appendix I. Appendix XIII contains the Standards for Community Mental Health Services.

Interviews were conducted with the Assistant Director and the Coordinator of Community Mental Health Services. Their responses relative to the six specific questions of this study are recorded below.

QUESTION	RESPONSE
1. Goal Establishment	The Assistant Director explained that he works with the Executive Directors of the centers to

set up state-wide goals, broadly defined. He sits on several committees with the Executive Directors. The Director of the Division of Mental Health has the final say for the Division on matters of goal-setting. When goal-setters, means-setters, change-setters (the Executive Directors, and the Office of Community Mental Health) don't agree, the Assistant Director related that consensus is sought. "When proposals for change from the Divisions are presented to the Executive Directors and they don't like them, the Division backs off and doesn't force Division proposals on the centers". There is a peer process that is involved. The Division, he said, used to be more authoritarian. It is now much more democratic. All decisions are majority rule decisions among the entire group of goals, means and change-setters.

The Coordinator noted that the centers have their own goals and that the Division tries to make these goals concrete and measurable. Budgets, goals and objectives are submitted to the Division each year. If the Division doesn't agree, he said, they are returned to the centers and questioned. When goals, means and change-setters disagree, the Coordinator explained that certain courses of action are taken, depending on the area of disagreement. "If a center violates a standard a firm position, hard line is taken to exercise control". "Centers have

to change", he said. "If data doesn't come in, we hold up quarterly checks until it comes in". "We don't like to tell the centers how to run their programs, but if a program gets too fat financially, we won't give them the requested money if alternatives exist". Other areas of disagreement are negotiated he said, and may go in favor of the centers. If the Executive Director of a center and the Division disagree, the matter may go to that center's Executive Board, noted the Coordinator.

2. Means Establishment

The Assistant Director explained that the Division works with the Executive Directors on matters of fees, finances and funding priorities. They direct funding and act as a source for other funds, especially federal.

The Division provides technical assistance, as in writing grants, and accountant services to the centers, related the Coordinator. "Legislative appropriations come from the Division which is controlling center programs through financing", he continued.

3. Feedback

The Assistant Director receives both solicited and unsolicited feedback. "Complaints are infrequent," he said. This feedback he communicates to the centers or their Boards. A list of his feedback sources appears in Table XXVI, Appendix IX.

The Coordinator reported that he travels to the centers and to various community agencies and receives feedback from all of them on the performance and needs of the centers, their Boards, recording systems and the like. He sends data from New Hampshire Hospital to the centers. The Coordinator related that he meets with the Executive Directors on his initial visits, next with the staff and will meet later with the Executive Boards. His complete list of feedback sources appears in Table XXVII, Appendix IX. He reports this feedback directly to the centers, and from the centers to the Division. He explained that he tries to keep in close contact.

4. Evaluation and Assessment

The Assistant Director explained that the Coordinator gathers the information on the progress of the centers' programs that are financed by the State. The Division works with the Executive Directors on changing priorities of programs re: funding and technical assistance. The Division has forced certain changes through the development of statewide standards.

Assessment, noted the Coordinator, is the difficult part of accountability. "It began with finances and statistics, but the effectiveness is difficult and subjective." The Coordinator said he suggests programs and program developments to the centers.

5. Time and Stage Sequence	The data collected from the Office of Community Mental Health indicates that goals and means are established and re-established at regular, formal meetings. Feedback is regular, fairly systematic but not entirely continuous. Therefore, the social feedback model used by Buckley may apply better to the Division than to the mental health centers.
6. Decision-making	The Division is a member of the Control Center in Buckley's model. It is involved with establishing and re-establishing goals and means, on an organizational/policy level, for the centers. It is not directly involved in therapeutic decisions, though it influences the programs that centers offer by controlling a significant portion of the funding. The degree of authoritarianism or equalitarianism that is exercised by the Office of Community Mental Health is unclear as the interviews were somewhat conflicting. This may vary depending on the issues and the personalities involved.

CHAPTER IV

ANALYSIS

> The significance of a model depends on how well it serves its purpose The purpose of industrial dynamics models is to aid in designing better management systems. The final test of satisfying this purpose must await the evaluation of the better management. In the meantime the significance of models should be judged by the importance of the objectives to which they are addressed and their ability to predict the results of system design changes. The effectiveness of a model will depend first on the system boundaries it encompasses, second on the pertinence of selected variables, and last on the numerical values of parameters. The defense of a model rests primarily on the individual defense of each detail of structure and policy, all confirmed when the total behavior of the model system shows the performance characteristics associated with the real system. The ability of a model to predict the state of the real system at some specific future time is not a sound test of model usefulness.[1]

Data on the feedback processes in New Hampshire's mental health centers has been collected and presented. This information provides clumsy and unclear answers to the specific questions of this study. To be more direct and focused and illuminating, this chapter will be arranged to first of all pull together and analyze the material that should answer the first four questions. The material for each of the four sampled centers plus the Division of Mental Health will be presented separately.

Following this a comparative look will be taken of these findings to determine what similarities and differences appear among the four mental health centers. This study is not a complete organizational analysis, but within the framework of organizational self-regulation, certain observations and conclusions can be made about the relationship of selected organizational variables and the nature of feedback processes.

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[1]Jay W. Forrester, Industrial Dynamics, Cambridge, Mass., The MIT Press, 1961, p. 115.

The material relevant to the fifth question on the sequence of stages has already been presented. Upon reviewing this, some expansions will be provided, particularly as they tie in with work undertaken by others interested in feedback.

Finally, the sixth question dealing with social feedback models will be presented. In the light of the data collected, an elaboration to the current social feedback model will be put forth in the hopes that it will be helpful in understanding complex organizations. Means by which this proposed elaboration can be coordinated with other organizational diagrams will be explained.

Taking the mental health centers in the order in which they were presented, the Manchester Community Mental Health Center feedback processes are analyzed first.

As was pointed out earlier, the decision-making within mental health organizations can be more or less cleanly divided into two categories: organizational issues (eg. fiscal matters, organizational structure, procedures, size, relationships with the surrounding community and its agencies, general philosophical/political orientation) and clinical issues (eg. the handling of specific clients or client groups, the effectiveness of treatment modalities, referrals to and coordination with specialists and their facilities). (N.B. Some decisions or problems have both clinical and organizational aspects). Within the Manchester center, organizational goal establishment and re-establishment, Question #1,[2] appears to be handled in a relatively traditional manner. Input is received by the administrators from the clinical and clerical staff.

[2]The exact wording of this question and the five others appears with the conclusions to these questions further in the chapter.

This input, coupled with the feedback they receive and the environmental disturbances are used by the administration to determine and change organizational goals and policies. (Disturbance is a term referring to the set of other factors that influence decision-making, and the environment, such as current political and economic events, relevant scientific research, and the personal needs and goals of involved personnel. This term will be considered further in connection with the model proposed under Question #6). The Executive Director reviews all decisions and exercises final authority over them. These decisions, or the most important ones among them, are nominally reviewed by the Executive Board. This process is represented in the diagram below.

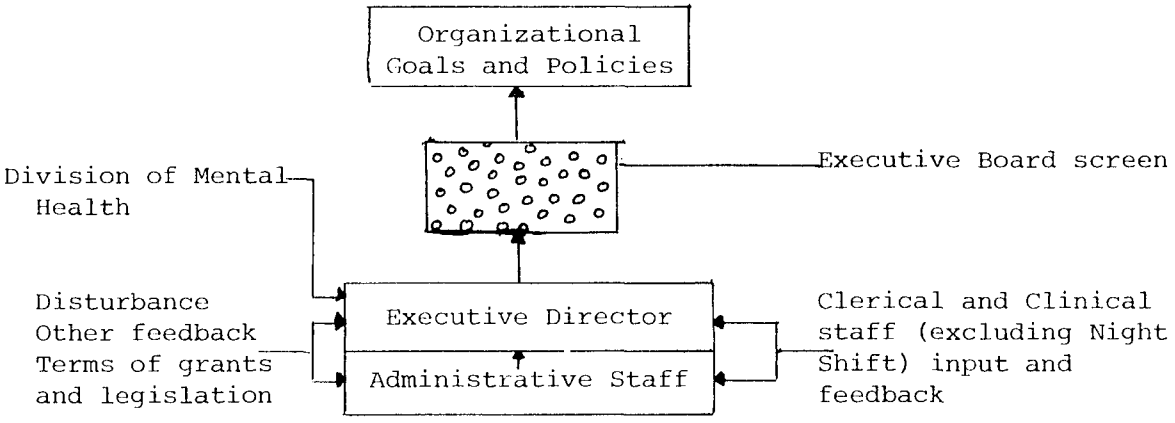

Figure 3. Organizational goal establishment and re-establishment within the Manchester Community Mental Health Center

The process of establishing and re-establishing clinical goals occurs in a somewhat less traditional fashion. Administrators and clinical staff tend to jointly work out clinical goals. This process is undertaken chiefly during daylight work hours and so the Night Shift is only minimally involved. These goals are reviewed by the administrative staff. Figure 4. illustrates this process.

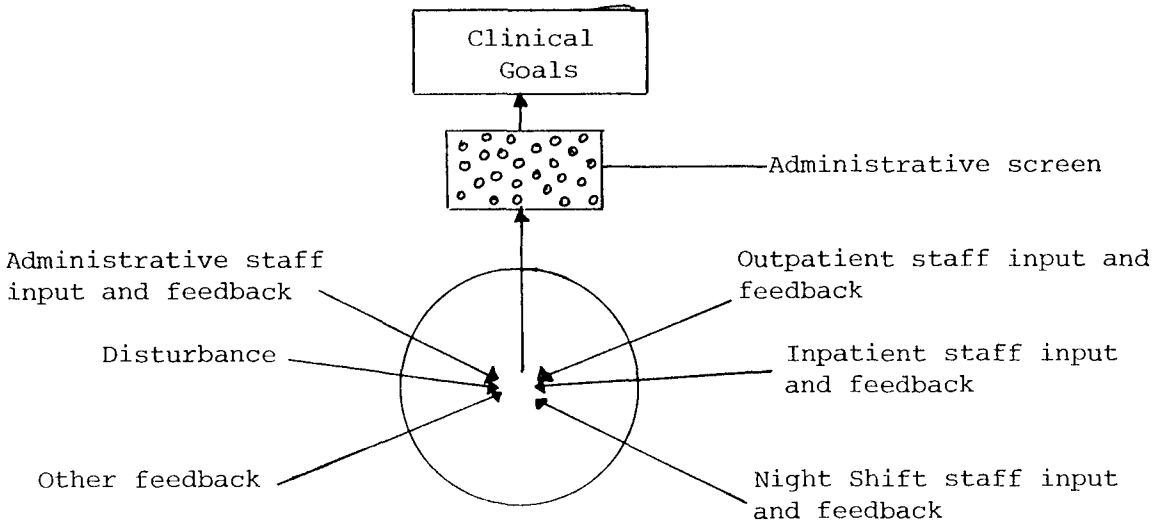

Figure 4. Clinical goal establishment and re-establishment within the Manchester Community Mental Health Center

Organizational means establishment and re-establishment, Question #2, takes place in a similar though not entirely identical fashion as does goal-setting. The essential difference lies in the more colleagueial relationship between the Executive Director and his administrative staff in these matters. The process of establishing and re-establishing clinical means involves a greater degree of clinical staff autonomy. Certain decisions are made by this staff without administrative sanction. Figures 5. and 6. illustrate the process of establishing both types of means. (Within the Manchester center and the three others in the sample, not all organizational goals and means are reviewed by the Executive Board. Particularly matters related to organizational structure or policy within individual programs may be decided on at the administrative/staff level.)

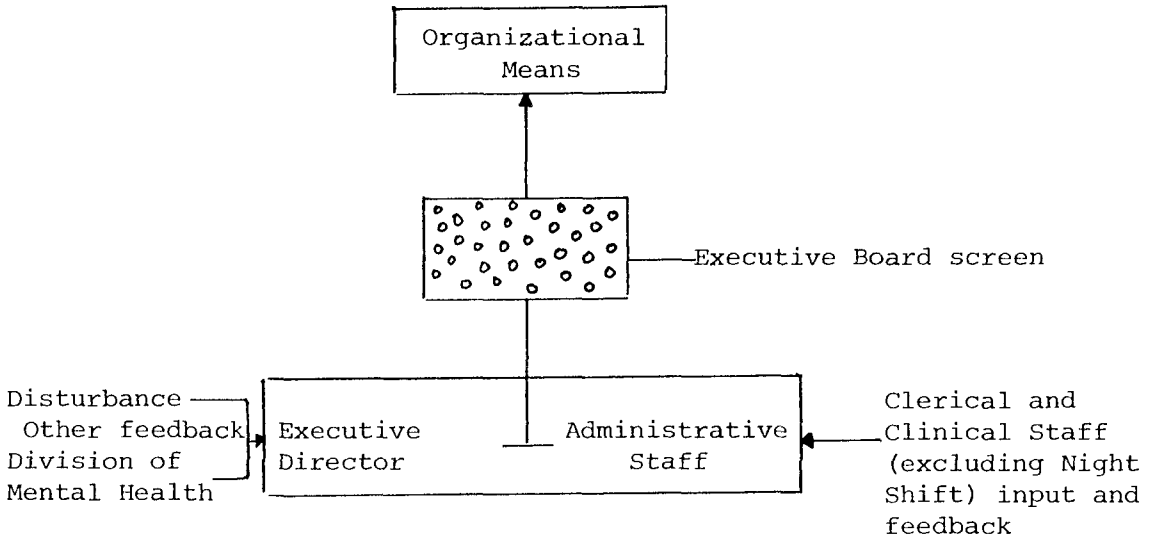

Figure 5. Organizational means-establishment and re-establishment within the Manchester Community Mental Health Center

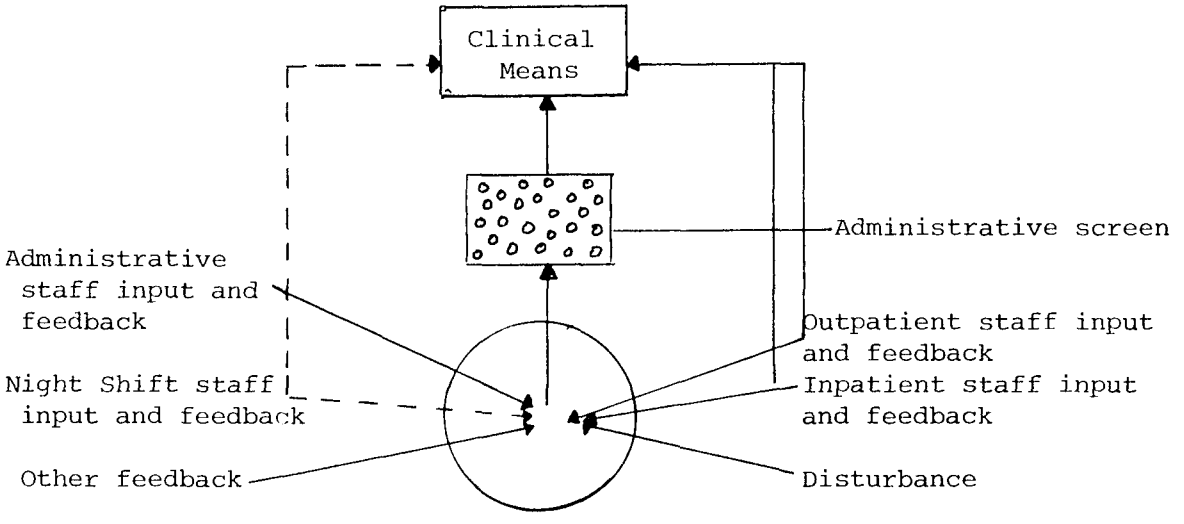

Figure 6. Clinical means establishment and re-establishment within the Manchester Community Mental Health Center

Feedback, Question #3, within the Manchester center has the following characteristics:

a. Administrative internal feedback is both systematic (received according to a fixed schedule or at regular intervals, and in an instituted manner, as in weekly meetings) and unsystematic. Some

of it is formal, though most of it is informal.

b. Administrative external feedback is essentially unsystematic, formal and informal.

c. Out-patient staff internal feedback is a combination of systematic and unsystematic feedback. It is more oral than written; more informal than formal; sometimes inadequate for the staff's purposes, by their own definition especially when the source is other staff and the administration. The internal feedback is, however, mainly adequate and seldom an overload. Internal feedback comes chiefly from three sources, staff, administration and the Division of Mental Health.

d. Out-patient external feedback is unsystematic the vast majority of the time. It is somewhat more oral than written; about equally formal and informal; sometimes inadequate, but more often adequate and rarely an overload. Roughly one-fifth of the sources are mutual to the majority of the staff.

e. Night Shift staff internal feedback is systematic and unsystematic; equally formal and informal; completely inadequate and limited to other clinical staff and the administration.

f. Night Shift staff external feedback is unsystematic, essentially oral and informal, and severely limited.

g. In-patient staff internal feedback is largely oral. The majority of it is informal and adequate; never an overload; and comes fairly exclusively from the clinical staff and the administration.

h. In-patient staff external feedback is also largely oral; somewhat more informal than formal; sometimes inadequate but more often adequate, and seldom an overload. As with the Out-patient staff, about one-quarter to one fifth of the sources are common to most staff, while the other three-quarters (four fifths) of the sources come to only one or two staff members.

i. For Executive Board members the vast majority of the feedback comes from two sources, the Executive Director and the Business Manager. This feedback is generally formal and often systematic. The Board's other feedback sources are haphazard.

j. The clerical staff function to communicate and channel internal and external feedback.

In the Manchester center, as in all the others sampled, external feedback is essentially unsystematic. The feedback from some sources may be very frequent, once a week or more. But since most of that feedback is not received at set, designated intervals, it may often have the effect but not the quarantee of systematic feedback. Some of the external feedback sources come in as infrequently as once a year.

Evaluation, Question #4, of organizational goal attainment is formally and informally undertaken by the Executive Director and his administrative staff. The role of the clinical staff in these evaluations is unclear, but apparently limited. Clerical staff participate in the evaluation of the clerical routine. The Executive Board's involvement in organizational evaluation, by their account, is limited to fiscal assessments.

Evaluation of clinical goal attainment is undertaken by the clinical staff in groups, individually, or with the administrative staff. Collective staff evaluations were reported to be seldom among Out-patient staff, but fairly frequent, both formally and informally, among In-patient staff and Night Shift staff. Since many indicated that the clinical goals are not very clearly defined, the process of evaluation must include a considerable amount of uncertainty.

Turning to the data collected at North County Community Services in Berlin, one finds a pattern of decision-making that is not altogether unlike that in Manchester. Organization goals and policy establishment and re-establishment, Question #1, are controlled in large measure by the Executive Director. Figure 7. indicates his role and relationship to others within the organization.

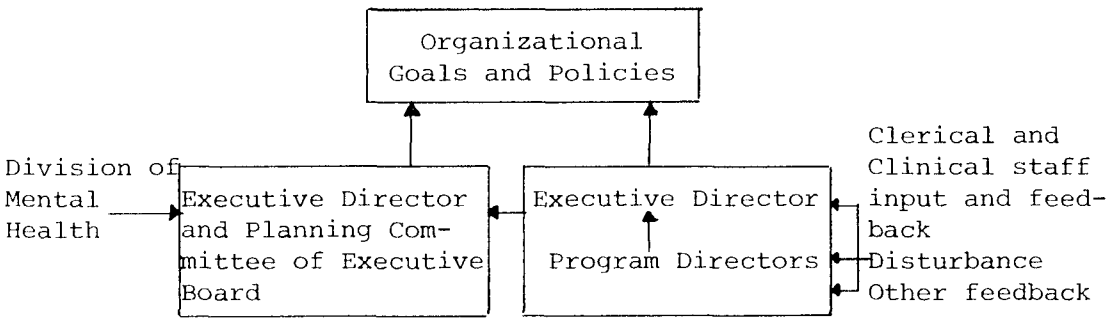

Figure 7. Organizational goals establishment and re-establishment within North Country Community Services

It should be noted that the Executive Board interviewees reported that the Board is not involved with goal-setting, as was reported by the Executive Director. Neither Board member interviewed, however, was a member of the Planning Committee, see Figure 7.

Clinical goals may be variously established and re-established within North Country Community Services. The autonomy of individual staff may

vary with the case and the appropriateness of singular or collective decision-making. In any case, the Executive Director has delegated this function to others and generally is not involved with it. Figure 8. illustrates the process.

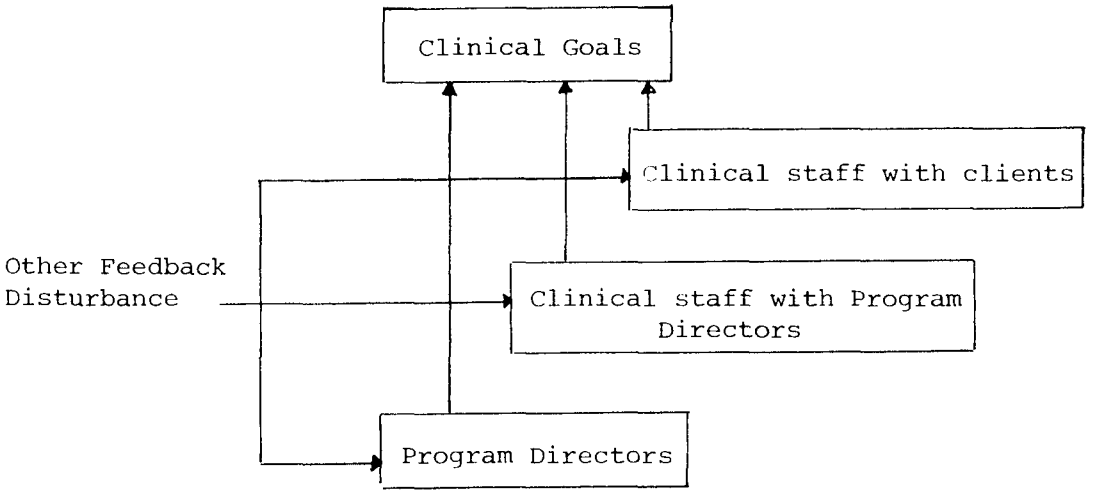

Figure 8. Clinical goal establishment and re-establishment with North Country Community Services

The responsibility for establishing and re-establishing organizational means, Question #2, has been largely delegated by the Executive Director to his program directors. He does retain a final sanctioning function as does the Executive Board, to whom are channeled major organizational means proposals. This process is represented in Figure 9. Figure 10. illustrates the process by which clinical means are established and altered. As with clinical goals, some clinical means decisions are made by the therapist and client directly. Others involve consultation with other staff and/or the program director. In certain instances the Executive Director may review the decisions.

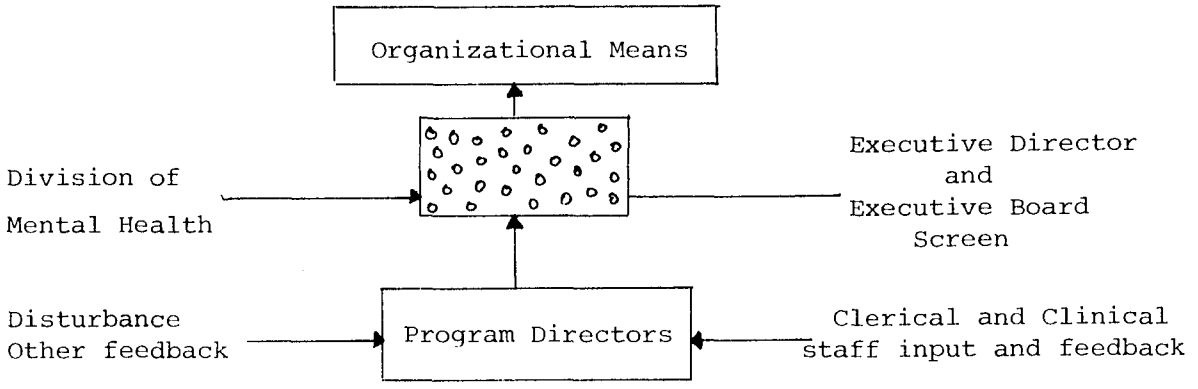

Figure 9. Organizational means establishment and re-establishment within the North Country Community Services

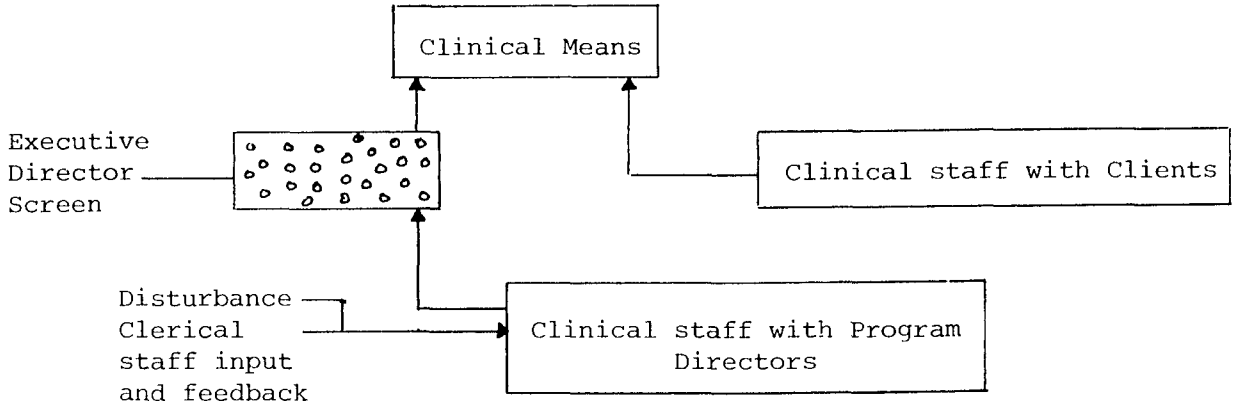

Figure 10. Clinical means establishment and re-establishment within the North Country Community Services

Feedback, Question #3, within the Berlin center has the following characteristics:

a. Executive Director internal feedback is both systematic and unsystematic; formal and informal.

b. Executive Director external feedback is unsystematic, and again both formal and informal.

c. Clerical staff communicate and channel internal and external feedback. They may exercise a certain amount of gatekeeping

in this process. They receive significant amounts of unsystematic informal feedback from the local community.

d. Clinical staff internal feedback is systematic and unsystematic; largely oral and informal. Seldom is it reported to be inadequate and never an overload. There are two principle sources: the staff and the administration.

e. Clinical staff external feedback is unsystematic, and again generally oral and informal. It is described as being predominately adequate, though sometimes inadequate and, rarely, an overload. Over three-fifths of the sources are common to only one, two or three staff members.

f. Executive Board internal and external feedback is systematic and unsystematic; formal and informal.

Organizational evaluation, Question #4, is undertaken by the Executive Director with the aid of the program directors. Clerical staff have input into office routine evaluation. The Executive Board, it was reported, is not actively involved with evaluation and assessment.

Clinical evaluations are made regularly in formal and informal sessions by the clinical staff and the program directors. Evaluations are made against goals which are reported to be clear enough to serve as a standard of comparison.

At White Mountains Community Services in Littleton the pattern of organizational decision-making, Question #1, is somewhat different than that found in the centers in Manchester and Berlin. The Executive Board has the final vote on such decisions and the Executive Director the final

responsibility on goals presented to the Board. However, the process of arriving at organizational goals and changing them begins with a highly democratic discussion involving all staff. When concensus or a majority position is achieved, the proposed goal is sent on to another body that operates on the majority rule system, the Executive Board. The Executive Director, by reports, functions to cast the deciding vote in the case of a tie or complete disagreement among the staff, but he does not exercise a strong hand or authoritarian rule. See Figure 11.

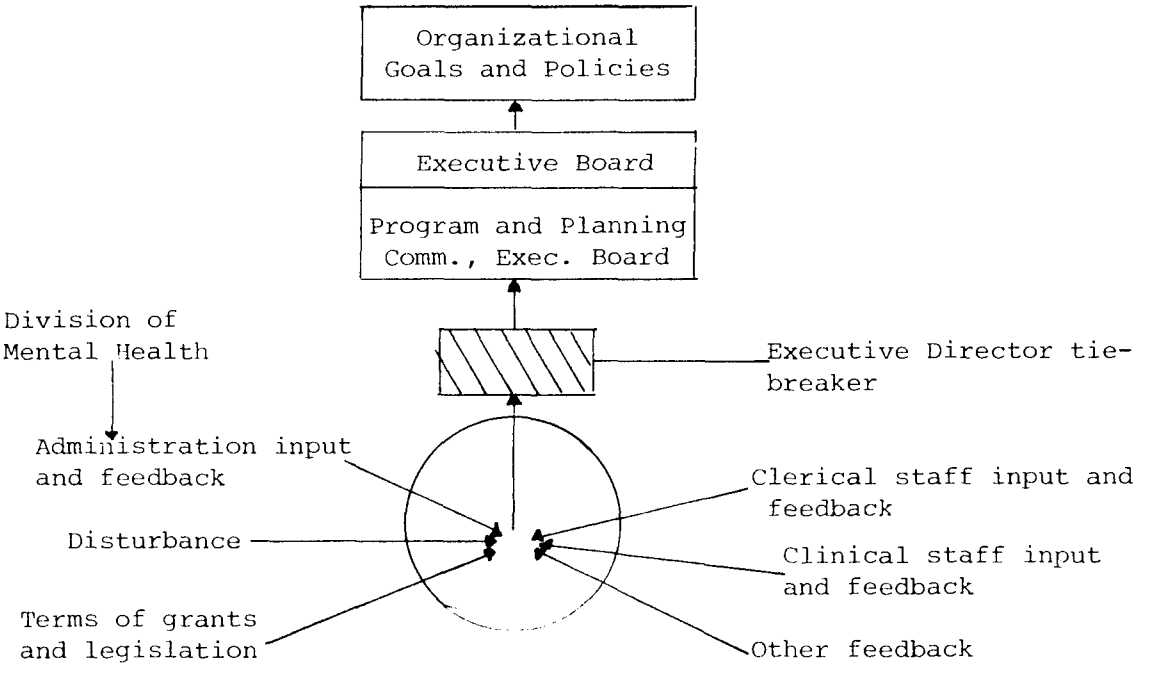

Figure 11. Organizational goal establishment and re-establishment within White Mountains Community Services

Clinical goals are set and altered in a fashion similar to that in the Berlin center. Sometimes the goals are established directly by the therapist with input from all staff at weekly staffings. At other times the program directors or the psychiatrists may make a decision, though generally not without staff input. The degree to which the clerical staff

participate in clinical decisions is unclear. By their own report they do not participate to any significant extent. By the report of the rest of the administrative and clinical staff, they do. Figure 12. details clinical goal-setting.

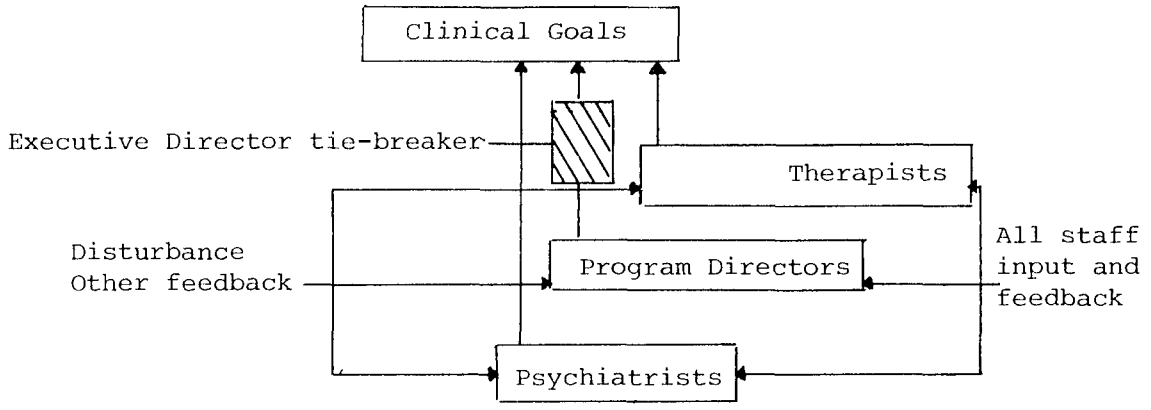

Figure 12. Clinical goal establishment and re-establishment within White Mountains Community Services

The processes by which organizational and clinical means, Question #2, are established and re-established within the Littleton center are essentially the same as are illustrated by the figures for organizational and clinical goal-setting. A diagram of organizational means establishment would be identical to Figure 11, Organizational Goal Establishment. By adding an input from the Executive Board President to the Program Directors, and changing the input of 'all stall' to 'administrative and clinical staff', Figure 12, Clinical goal establishment, would also diagram clinical means establishment.

Feedback, Question #3, within the Littleton center has the following characteristics:

a. Administrative internal feedback is systematic and unsystematic, formal and informal.

b. Administrative external feedback is generally unsystematic, again both formal and informal.

c. The Clerical staff function as a communications link for internal and external feedback. The data suggest a small amount of gate-keeping regarding informal feedback.

d. Clinical staff internal feedback is systematic and unsystematic. It is mainly oral; somewhat more informal than formal, over-whelmingly adequate and never an overload. Board members are included as a source for most clinical staff.

e. Clinical staff external feedback is unsystematic, largely oral, and both formal and informal. It is generally adequate for the staff's purposes, though occasionally inadequate. Almost nine-tenths of the sources are not common to the majority of the staff members.

f. Executive Board feedback is systematic and unsystematic, formal and informal.

Organizational evaluations, Question #4, are conducted chiefly by the administration. These evaluations are often informal. Clerical staff participate in evaluating office procedures. Executive Board members feel they have no criteria by which to make evaluations and assessments, especially regarding service delivery. They are attempting to change this exemption in their role by involving themselves with administrator evaluations.

Clinical evaluations are handled by the clinical staff in regular formal meetings and in frequent informal ones. Some felt that the goals of

the services are clear enough to serve as a performance standard; others disagreed. This undoubtedly complicates the evaluation process.

As we move on to the fourth center in the sample, it becomes evident that certain patterns of decision-making re-occur within mental health centers. The picture of goal establishment and re-establishment, Question #1, at Carroll County Mental Health Services in North Conway and Wolfeboro is very similar to that in Littleton. The Executive Board and Executive Director review organizational goals jointly arrived at by the entire staff. Figure 13. details this.

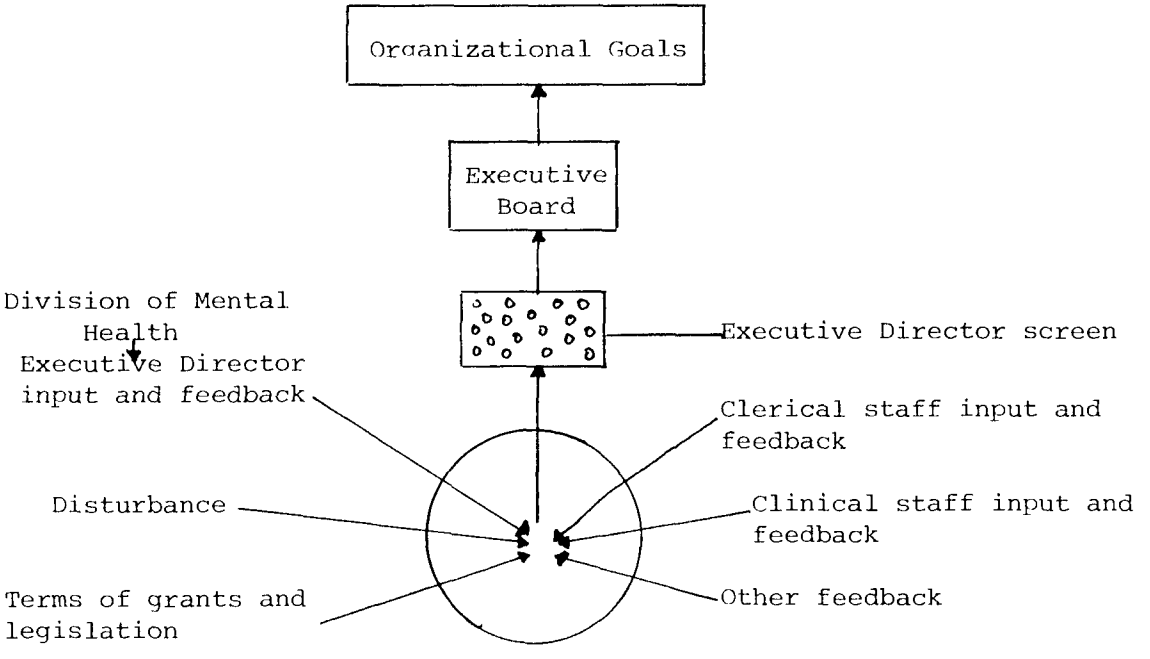

Figure 13. Organizational goal establishment and re-establishment within Carroll County Mental Health Services

Figure 14. details clinical goal setting at the North Conway and Wolfeboro centers. As with the two previous centers, clinical goals may be variously established, allowing room for a certain amount of therapist autonomy.

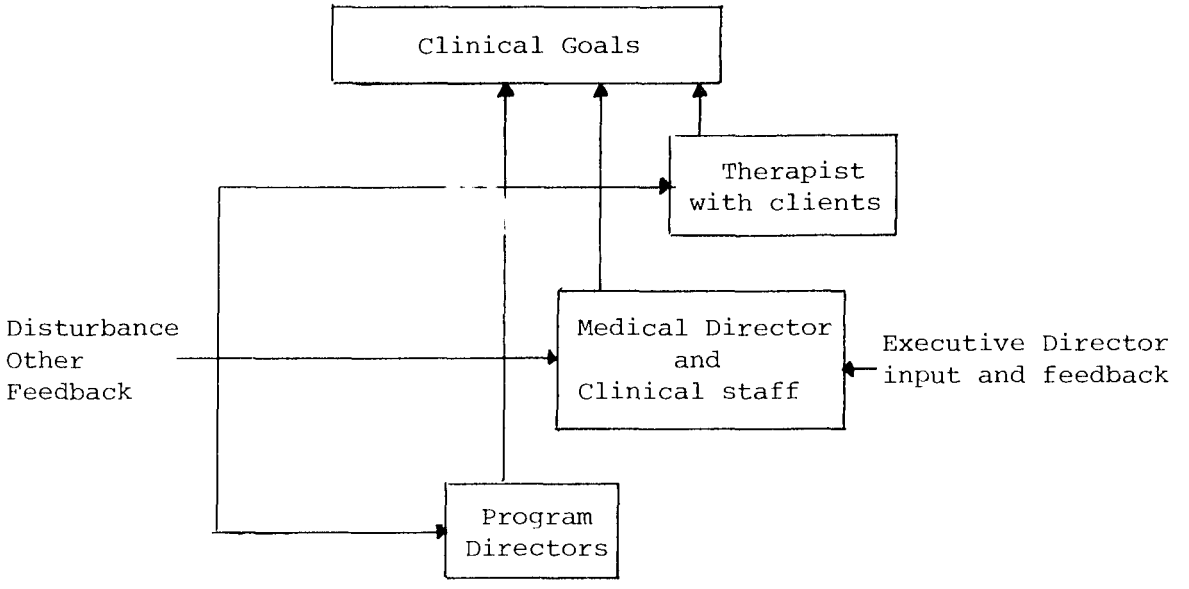

Figure 14. Clinical goal establishment and re-establishment within Carroll County Mental Health Services

The processes by which orginizational and clinical means, Question #2, are established and re-established are almost identical to those of organizational and clinical goal-setting. By deleting 'terms of grants and legislation' from Figure 12. that diagram would also represent the process of establishing organizational means. Adding 'supervisor' to the input of therapists with their clients in Figure 14. makes that diagram an illustration of clinical means establishment as well as clinical goal establishment. This means that the same people are involved in the same way for both goals and means-setting and altering.

Feedback, Question #3, within the North Conway and Wolfeboro centers has the following characteristics:

a. Executive Director internal feedback is systematic and unsystematic, formal and informal.

b. Executive Director external feedback is unsystematic, formal and informal.

c. The Clerical staff function as a communications link for internal and external feedback.

d. Clinical staff internal feedback is both systematic and unsystematic. It is more oral than written; about equally formal and informal; largely adequate, though sometimes inadequate, and rarely an overload. Five of the seven sources are common to at least half of the staff.

e. Clinical staff external feedback is unsystematic, largely oral, and about equally formal and informal. It is generally adequate, though sometimes inadequate and an overload. A little less than half the sources are common to 50% or more of the staff.

f. Executive Board feedback is systematic and unsystematic, formal and informal.

Organizational evaluations, Question #4, are undertaken chiefly by the Executive Director. The clerical staff participate in the evaluation of office procedures. Executive Board members play a minor role in evaluation, by their account.

Clinical evaluations are made by the clinical staff. As in the two previous centers, there is a divergence of opinion regarding the clarity of goals and their usefulness as goal attainment standards. This must complicate the evaluation process, influence assessments of effectiveness, and have a bearing on the increasing demands for accountability, especially where third party payments are involved.

The New Hampshire Division of Mental Health plays a significant role in the establishment of mental health center organizational goals

and means, Questions #1 and 2. As organizational goals and means bear on clinical goals and means (see below), the Division has influence upon the latter, but in no direct way. Key personnel from the Division meet with the Executive Directors regularly to work out uniform, statewide goals and policies. The Executive Directors in turn bring this information to their own centers where it functions as a parameter for the consideration of that center's goals. In the preceeding diagrams of organizational goal establishment this process is indicated by the input arrow from the Division to the Executive Directors. This input is more than suggestions and may carry financial sanctions with it, as the Division acts as the dispersing agent for State and federal funds.

The Division acts in both an assisting and advising role and as a co-parameter setter with the Executive Directors where organizational means are concerned. Assistance of various sorts is offered to the administrative staffs of the centers. Uniformity and promptness of certain organizational procedures are demanded. Financial sanctions may or may not be used, depending on the Division personnel involved.

The internal feedback, Question #3, received by the Division of Mental Health is both systematic and unsystematic; formal and informal, oral and written. The external feedback is generally unsystematic; formal and informal, and largely oral.

The Division involves itself in evaluation, Question #4, in the same way they involve themselves with goals and means setting. They are appraised of the status of things within the centers, and then evaluate and assess this status with the Executive Directors. This acts as important, often binding, input to the Directors.

A summation can be made of the findings from descriptive questions # 1-4 on the nature of the feedback processes in the mental health centers in New Hampshire.

Question #1. How are policies or goals established and re-established in the mental health centers of New Hampshire?

Question #2. How are means established and re-established in the mental health centers of New Hampshire?

In the four sample mental health centers in New Hampshire, the clinical goals and means setters, or the Control Center in Buckley's model, includes the clinical staff as well as the administration. There is a collegial decision-making arrangement (jointly among associates) among the staff regarding the delivery of services. (This may, but often does not include the clerical staff.) The goal setters are also the means setters and the means implementers. A more traditional or authoritarian hierarchy does not pertain in the matters for which the professional staff has been trained, usually with advanced academic degrees. The Executive Director of a New Hampshire mental health center is likely to be a social scientist and may participate as such with his staff in arriving at clinical decisions. (Within the large center in the sample, the collegial relationship is best seen within programs.)

The sampled mental health centers in New Hampshire exhibit two divergent processes concerning the establishment of organizational goals and means. This divergence is noteworthy in the pursuit of identifying relationships between selected center variables and the nature of feedback processes. In two of the small, northern, rural catchment area centers the decision-making body (Control Center) for organizational

matters includes the clinical staff. In the other two centers clinical staff are not included. After looking at only the Manchester data it was felt that clinical staff exclusion in organizational decision-making might reflect a necessary role distribution due to the size of the staff. When that exclusion was also found in the relatively small center in Berlin (less than 20 staff members), and not in the other two small centers, it was determined that region of the state and type of catchment area (rural or urban) were not predictably involved in a relationship with the nature of the decision-making processes. However, size of the center and the organizational role distribution preference of the Executive Director probably were. Small centers may have a collegial decision-making process for organizational matters or a more traditional one, depending in large measure on the preference of the Executive Directors. (New Hampshire Executive Directors have considerable latitude in the establishment of administrative processes.) Large centers (more than 40 staff members) probably can not have a strictly collegial decision-making process involving clinical staff in organizational matters because of size limitations. (Thirty or more people in a decision-making process is unworkable and would necessitate considerable delegated representation.) Large Centers may have either a collegial or a traditional decision-making process within an administrative group, depending on the preference of the Executive Director. It may be observed that participation in clinical decision-making carries with it a requirement for clinical education, while participation in organizational decision-making does not apparently carry with it a requirement for administrative education. Two of the four Executive Directors in the sample were clinicians by education and experience, and not administrators.

Executive Boards of New Hampshire's mental health centers are governing bodies composed of lay people who live within the catchment area of their center. The Boards and the Executive Directors have the ultimate responsibility for the organizational and clinical decisions made at the centers. They may be liable parties in the case of a legal suit against the centers. Executive Board members are not expected to be social science professionals, and therefore their role in the major aspects of clinical decision-making can be, and is in the four sampled centers, little more than giving approval to the judgements of the social science professionals. The extent to which the Executive Boards take a more active decision-making role in organizational matters varies from center to center and with the issues. No relationship was found between the size, location and nature of the catchment area and the role played or not played by the Executive Boards. All Boards seem to be actively involved with fiscal issues, but sometimes more passively involved with other organizational matters. This may in part be understood if one looks at their feedback sources, the number of sources and their characteristics. Generally, Executive Boards rely heavily on their Executive Director for the majority of their feedback. They have few external feedback sources, and these tend to be unsystematic. The amount and variety of feedback information that they either solicit or receive unsolicited does not seem commensurate with the amount of responsibility they are called upon and do assume.

This study has consistantly distinguished between decisions that mental health center staff and affiliates make about organizational goals and means and clinical goals and means. Logically there should be a relationship between the two types if organizational self-regulation is

to be effected to any extent. Viewing the ideal relationship in terms of a hierarchy of goals and means, the attainment of organizational goals would in large part take place through the attainment of clinical goals, provided that the two types were coordinated. Coordination can only occur in the presence of adequate communication and feedback. In the sample centers of this study, that coordination, to whatever degree it occurs, takes place through the mechanism of internal feedback which is systematic (as well as unsystematic) and regular. Personnel from all groups within the centers meet with each other, and by their accounts, exchange feedback that should allow for such coordination.[3]

Within an organization that exhibits some degree of goal hierarchy, goals and means change categories. The means at one level become the goals at the next level down. In this study organizational means set by the Executive Director and/or the administrative staff may become the goals of individual program directors or clerical staff. Clinical means set by program directors with or without their clinical staff, may become the goals of individual therapists, workers and volunteers. The presence of a hierarchy involves a sequence of goals and means transitions. This sequence occurs over time. The greater the number of intermediate goals, the greater the time involved. A progression of goals is illustrated by Joseph Litterer in the following diagram.

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[3]In the pre-test center at Lewiston, Maine, there existed a serious communications gap among all parties, resulting in divergences of organizational and clinical goals and means. Consequently, the center came into serious fiscal and other difficulties which nearly resulted in the termination of the entire organization.

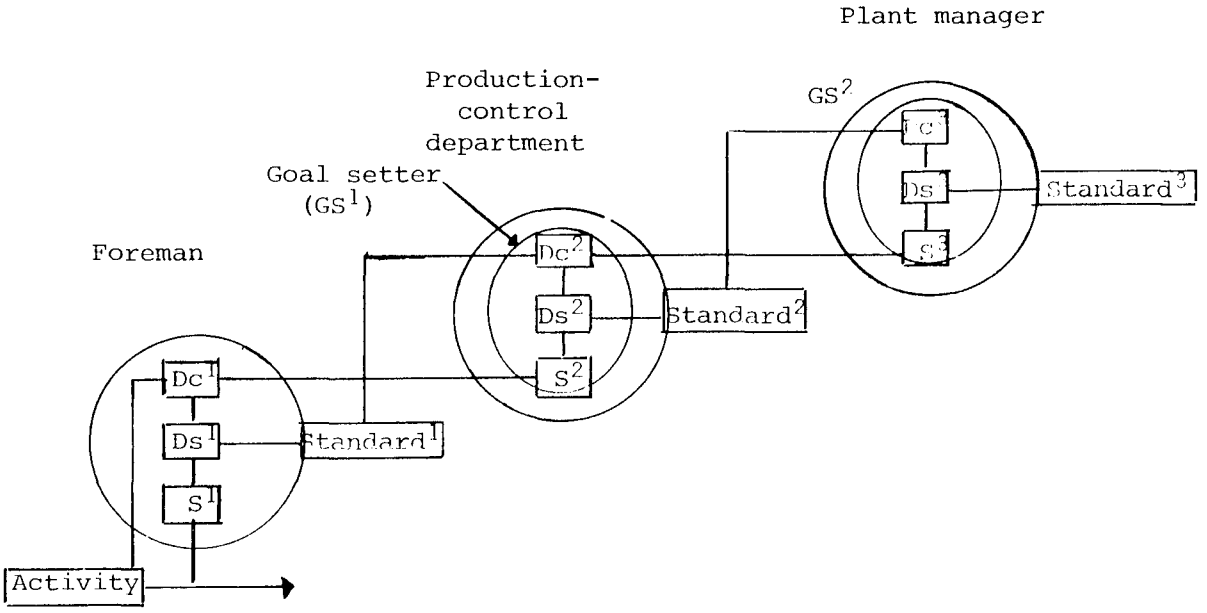

Figure 15. Progression of Goals and Control Loops, Joseph A. Litterer, from The Analysis of Organizations, New York, John Wiley and Sons, Inc. 1965, p. 247.

Question #3. What are the sources and characteristics of the feedback in operation in the social feedback processes of the mental health centers of New Hampshire?

It has already been pointed out that the internal feedback in New Hampshire's mental health centers is both systematic (recieved at certain designated intervales in an instituted manner) and unsystematic. The external feedback is largely unsystematic as no centers have established a regular feedback and follow-up system. Within the two categories systematic and unsystematic, the feedback may be formal and informal, oral and written and by observation, inadequate (for the staff member's purpose by his own description), adequate and an overload or too much information to handle, especially if that information is superfluous. Systematic feedback need not be formal and written. It may also be informal and oral. There does not seem to be significant differences in

the characteristics of the feedback in the small centers as compared to that in the larger one. In each of the four sample centers, certain staff members, for whatever reasons, receive much more feedback from many more sources than do other staff members. This means that some staff are dependent on others to provide them with the environmental testing necessary for organizational control.

Within the mental health centers some staff do receive feedback from some external sources that, though they may be unsystematic, are none-the-less very frequent, perhaps several times a week. This feedback may have the consequences of systematic feedback, but not the quarantee of continuation.

(Since feedback is the key to successful organizational control, what are the criteria for useful, adequate feedback? How does an organization insure a flow of useful feedback? Referring to the literature cited in Appendix XIV, useful feedback is regular enough to keep the receiver appraised of all changes in the environment. It does not have time lags that make the information out of date. It is complete, pertinent, accurate, multi-sided, clear, free of distortion and bias. A useful flow of feedback can only be insured by instituting feedback channels at all levels within the organization. These channels must be prepared to deal with the flow of information, be responsible for seeing that it is solicited and received and communicated, and, of course, utilized. Organizational members must be alerted to their formal and informal role in the feedback process, and alerted to the complicating factors that can influence feedback, such as personnel changes, con-

flicts, human error and the like.[4])

Question #4. How is feedback assessed and evaluated in the mental health centers of New Hampshire?

The diagrams at the beginning of this chapter indicate that evaluation in the mental health centers, on both an organizational and clinical level, is fairly regular and undertaken by or with input from all involved parties. The effectiveness of the evaluation depends on the nature of the internal and external feedback, and also upon the clarity of goal setting and the degree of coordination between goals and means.

At each of the stages in the social feedback process; goal setting, means setting and implementation, feedback gathering, evaluation and change, mental health organizations experience complicating circumstances and conflict. These are persistent elements in the organizational process. Their complete elimination is both unrealistic and probably undesirable. Conflict has numerous positive organizational consequences, such as stimulation, ferroting out problems and difficulties, new production and creativity. Conflict may bring out constructive group decisions. (Several interviewees in the study related that disagreements in decision-making are worked out so that consensus results. As was noted by others, it is probably just as common that such conflicts are handled by a vote with the majority ruling, rather

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[4]A suggestion was made by a family member of a mental health center client that all released in-patient clients and terminated out-patient clients be asked to fill out a form that asked the client and the family certain pertinent questions, such as whether their expectations had been met and how helpful the treatment had been.

than bringing everyone into complete agreement.) But conflict must not be allowed to mount to a level that brings significant disruption of the organization's self-regulating processes.

Question #5. Within the social feedback system of the mental health centers of New Hampshire, what is the relationship of time and the sequence of stages within the social feedback model?

In Chapter III data have been presented from each of the mental health centers in this study suggesting that, whereas feedback is the mechanism by which any type of organization may realize what consequences they are having on the internal and external environment, actual social organizational decision-making and implementation (i.e. control) does not always take place following the reception of that status-defining information. Decision-making in many instances may be a continuous process that is influenced regularly, or not so regularly, by feedback.

The social feedback models that are currently used including the one used by Buckley, all indicate that social feedback is a process that includes a number of stages. This process is a directional one in the models, with arrows indicating a sequence of stages. The arrows suggest that the previous stage triggers off the next one upon the completion of the previous one. No alternative action sequences are given, for in fact, each of these models is an ideal type based on one rational scheme of how organizations might operate. There are, however, other options for feedback processes that may reflect how organizations actually do operate.

The alternative in modeling proposed here is based on a concept that could be termed, 'the simultaneous regulation' model of social feedback. It is predicted on the idea that feedback is information relating to goals that enters into a larger process of control (decision-making and implementation, both rational and irrational) referred to as the social feedback process. (This process has been traditionally diagramed as a loop. The loop includes stages before and after the feedback.) Thinking in terms of the model used by Buckley, the stages of goal setting, means setting and implementation, evaluation and corrective action may be influenced by several factors other than feedback, such as an organization member's learning experiences, needs, goals, or current political and economic events. Sometimes these stages may operate without the benefit of feedback. Each of the stages, including feedback, is often in continuous functioning because of organizational necessity and the stimulation of these other factors referred to as disturbances. The social feedback process may be thought of as a process composed of several individual, though related processes, that are often in fairly continuous operation.

In "Feedback in Administration", Keith W. Warner[5] points out that administrations at all levels must make decisions without having adequate information about the consequences of these decisions. Frank Alexander[6] adds that it is not always possible or desirable to wait for an extensive study to produce better data. When decisions are made in the absense of complete, accurate, current feedback, there are several possible

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[5]Keith W. Warner, "Feedback in Administration", Journal of Cooperative Extension, Vol. V, Spring, 1967. p. 35-46

[6]Frank Alexander, "A Critique of Evaluation", Journal of Cooperative Extension, Vol. III, Winter, 1965, p. 212.

consequences: a. If a decision is made to change a goal, it will make it practically impossible to judge whether current goal attainment has been approximated, for when the feedback does come in, it will pertain to a previous goal and not the current one. If the goal adjustment is relatively minor, the feedback might still serve as a partial indicator of current attainment. And there is often a use for information that indicates how well previous goals were attained, even if new ones have already been set. But when goals are changed faster than feedback is received, true corrective action and self-regulation does not take place. Rather, the process is goal-hopping in an open loop or linear fashion.

b. If the goal is not changed, but a decision is made to change the means to achieving that goal before feedback is received about the effectiveness of current means, the attainment of goal may be jeopardized, enhanced, or even not seriously effected. But one would not know until later. Changes in means (or goals) may be made on the basis of projections based on previous experience (feed-forward). These projections may be fairly accurate, the end result being reasonably close goal attainment. The organization could also be unlucky and miss the mark badly.

c. If both goals and means are changed without the benefit of feedback, the decision-making process is entirely an open loop one, and does not fall within the field of cybernetics investigation.

By itself, feed-forward may be diagrammed as follows:

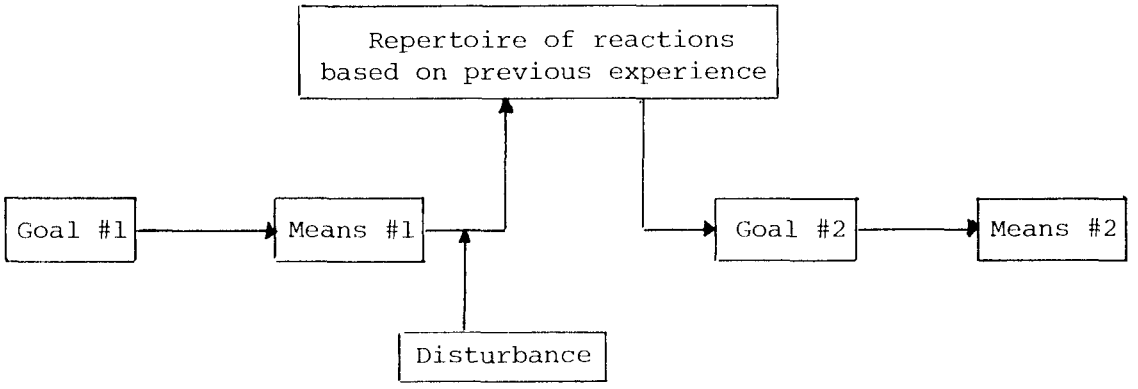

Figure 16. Feed-forward

Feed-forward assumes that a repertoire of reactions to certain conditions or event has been acquired by the organizational decision-makers through previous experience. When a certain configuration of circumstances occurs, such as a sudden decrease in funding or an increase in the demand for services, a routine response is available. This gives feed-forward one decided advantage over feed-back, and that is time. Decision makers can act immediately without waiting for information on the consequences of current goals and means. In times of serious threat to the organization or sudden environmental changes, this may be very important. If such a repertoire of reactions was not available to decision-makers in times requiring quick decisions those made would be fairly random, and would not carry with them a high probability of success; here feedback regulation would be essential.

Successful organizations may employ a combination of open loop and closed loop processes to regulate their goals and means. But if novel environmental disturbances are to be dealt with, the process of deciding by consequences must predominate in an organization that succeeds over time. Feed-forward can only be successful when only previously learned situations arise. As everything is in a state of flux, standardized

situations usually are not common. Feed-forward could never successfully operate as a permanent and prime process of organizational regulation.

Within social organizations there frequently exists a tolerance factor in goal attainment. Coming within a certain range of the goal is defined as being acceptable and not indicative of a need for goals or means alteration. Further, complex social organizations, at least on the short haul, have limits to their range of responsiveness or possibility for rapid change. For limited periods of time these factors may be important in keeping the organization from disintegration. If feedback, which for a time has not been present, returns to the decision-making process at a time opportune to realistic self-regulation, the status of the organization may be stabilized. In the situation where an organization sometimes makes decisions on the basis of complete, accurate and current feedback, and sometimes does not, that organization may persist. Later corrections may be sufficient to insure this.

The data from this study indicates that mental health centers are continually involved with setting and altering goals and means. Feedback may enter these decision-making processes and influence them to a greater or lesser extent. Feed-forward may enter these decision-making processes when required. Sometimes, for whatever reasons, feedback may not be received on an issue, but a decision is made anyway. Feedback may be received but ignored in the decision-making process. The feedback received may be incomplete or too late to be very helpful in the decision-making. The decision-making process at the goal setting, means setting and implementing, evaluating and changing levels is influenced by political events and relationships, by beliefs and values, and all other manner of

disturbances. These disturbance factors function to help perpetuate the decision-making stages of goal setting and altering and means setting and altering in the mental health centers in New Hampshire.

This process of organizational regulation by both feedback and feed-forward may be illustrated in an elaborated social feedback model. The elaboration would eliminate most of the arrows of more traditional social feedback models, and includes the influences of environmental disturbances. It would include lines between circles to indicate a relationship among stages, but not a necessary sequence among stages. Arrows on the circles would indicate that the stages may be in continuous operation. Goals and means may be changed in response to environmental as well as feedback information. The elaboration would be arranged to accommodate a feedback sequence of the traditional sort, where feedback stimulates organizational adjustment. But it could also accommodate the situation of feedback exclusion, feedback lag, feedback inadequacy, and feed-forward. Diagramed, this elaboration would be as follows:

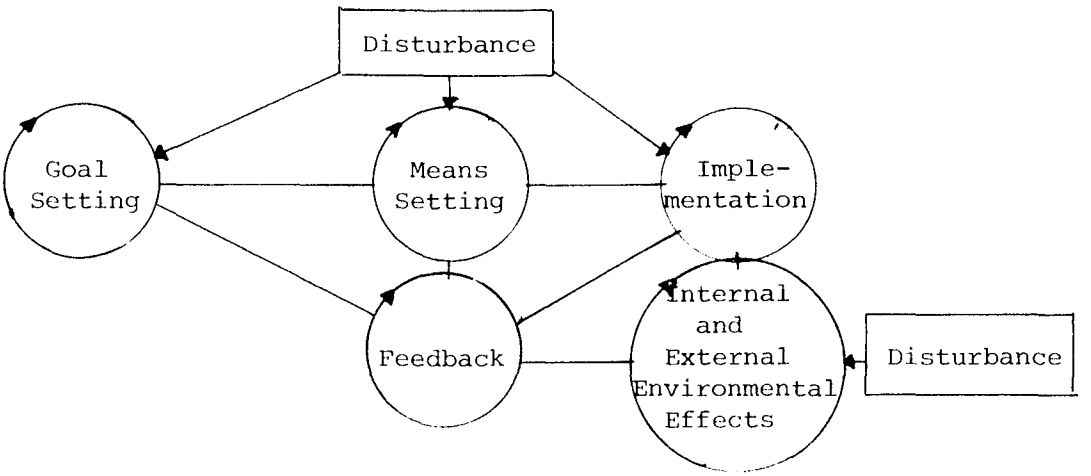

Figure 17. Elaborated Social Regulation model

This Regulation Model is designed to accommodate a higher degree of complexity and variation in the self-regulation process without the use of a complex and confusing scheme. It is still a general model. It would apply to all types of human organizations as do other social feedback models.

Question #6. Does the actual distribution of decision-making behavior in the mental health centers of New Hampshire suggest elaborations or clarifications in the social feedback model when applied to mental health centers?

The data for Question #5 has led to the development of an elaborated social regulation model. That model should describe feedback processes in traditional and authoritarian organizations as well as in collegial organizations where decisions are made jointly among associates. Standard feedback processes are explained by the model as well as the combination of open and closed loop processes. But it will do so on a general level. This study sought to discover whether a social feedback model could be drawn up that would specifically apply to mental health centers.

The first section of this chapter has included 8 diagrams (not to be confused with models) that detail organizational and clinical goals and means setting in each of the four sample centers. Each of these diagrams is somewhat different from the others, for each of these decision-making processes is undertaken in a separate way in each center. For the mental health centers there is no uniform Control Center composed of the administrative bodies that make decisions, as in the explanation offered by Buckley, see p. 3. The involvement of the administration, the clerical staff, the clinical staff, the Executive Board and the Division of Mental

Health varies. (There is a control function and not a control position). The data does not suggest a separate feedback model for mental health centers. But there is a way that the actual decision-making processes of this specific organization can be outlined within the larger framework of a general social feedback model. By combining the elaborated social regulation model with the specific diagrams for decision-making at each center, one combines the general model with case specific data for the purpose of illuminating the case specific. As an example: The diagram for organizational means setting at the Berlin center is represented by Figure 9.

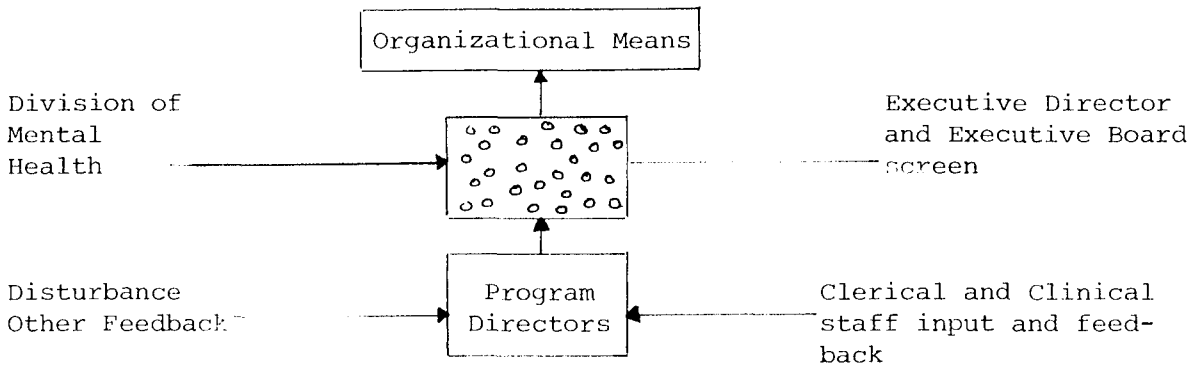

Figure 9. Organizational means establishment and re-establishment within North Country Community Services

The diagram for the elaborated social regulation model is represented by Figure 17.

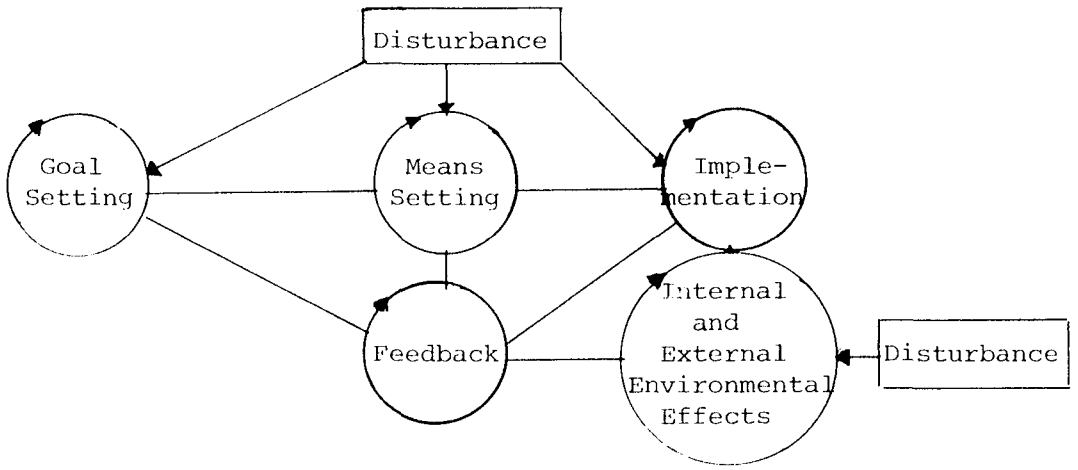

Figure 17. Elaborated Social Regulation Model

Figure 9. can be plugged into Figure 17, by placing the complete Berlin organizational means diagram within the means setting circle of the elaborated social regulation model. Figure 18. demonstrates this.

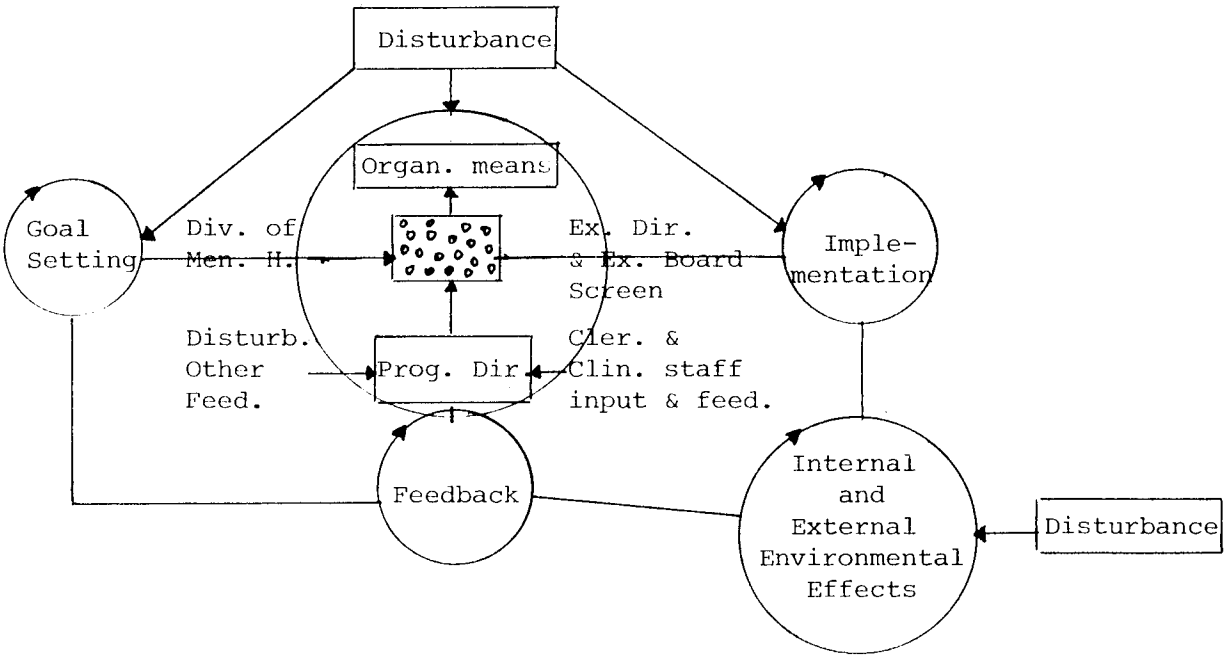

Figure 18. Organizational means establishment and re-establishment within North Country Community Services as seen within the framework of the Elaborated Social Regulation Model

This same procedure can be done with any of the goals or means setting diagrams from this study or diagrams that might be drawn for any other mental health center. As the elaborated social regulation model is a general one, specific decision-making diagrams from any type of organization could be plugged into it. Diagrams for the complete set of goals and means setting operations could be included in the appropriate circles, if there existed a relationship between or among them as is indicated by the connecting lines in the elaborated social regulation model. However, too many of these organizational processes squeezed together into one model probably would loose the impact of helpful explanation because of the complexity that would result.

The conclusion from all this is that the social regulation processes within the mental health centers of New Hampshire can be explained by an elaboration of an existing feedback model. Further enlightenment of these processes can be achieved by plugging case specific diagrams into this expanded model.

There is one more consideration this analysis should address itself to. That is the validity of the new model. At the beginning of this chapter a paragraph by Jay Forrester on judging model validity was quoted. Forrester contends that: 1. the significance of a model depends on how well it serves its purpose; 2. the effectiveness depends on the system boundaries it encompasses, the pertinence of selected variables and on the numerical values of parameters; and 3. the defense depends on the individual defense of each detail of structure and policy, all confirmed when the total behavior of the model system shows the performance characteristics associated with the real system.

The purpose of the expanded model in this study was to present a schematic representation that would enable description of a variety of types of social control in various organizations, and to do so in such a way that it would lend itself to specific case application. The model does this. The system boundaries are clearly limited to define the organizations the model is explaining. The model variables are essentially, with one addition, the variables of the model used by Buckley. Each detail of the structure and process of this elaborated social regulation model is drawn from carefully gathered data on real structures and processes. The model serves to describe the behavior of the real systems observed. On the basis of intellectual projection, it would appear to describe the behavior of a broad range of systems. The best reliability test will

come with the test of further research and study and the actual usefulness of the model to practitioners and theorists in the field.

CHAPTER V

CONCLUSION

This study has attempted to add to our understanding of complex human behavior by focusing in on the details of organizational feedback. The study was designed to provide descriptive information about the feedback processes of one type of social organization, the mental health center, and also to contribute to the existing body of theoretical material, including models on social feedback processes.

Four descriptive questions concerning the stages in social feedback were posed. The stages were those used by Buckley. In digest form the findings showed that: 1. Social feedback in mental health centers in New Hampshire is not a simple, well-ordered process. 2. Mental health decision-making can be divided into two categories: organizational/ policy and clinical. 3. A collegial relationship exists among the administrators and the social science professionals, (and sometimes the clerical staff) for joint decision-making, especially around clinical issues. 4. Decisions concerning organizational issues also include joint staff/ administration input, but, as in the case of the Division of Mental Health, the process may follow a more traditional form where top administration does the decision-making. See the feedback model used by Buckley. 5. The variables of geographic location of a center and the type of center catchment area are not predictably involved in a relationship with the nature of the decision-making processes and the nature of the feedback. The size of a center may have little influence on the presence of collegialship in decision-making, but may influence the delegation of responsibility. Large groups are not effective

discussion and decision-making groups, and so spokespersons, and representatives tend to be used. This delegation may appear in an administrative hierarchy. 6. Executive Boards of mental health centers have limited feedback sources and rely heavily on the Executive Directors for their information about the centers. They tend to be active in fiscal matters, but more passive regarding other center matters. 7. A great deal of the feedback that reaches the groups involved at the mental health centers is unsystematic, not received at regular intervals in an instituted manner. This is especially true of external feedback. While internal feedback is both systematic and unsystematic, external feedback tends to be largely unsystematic. This adds a degree of precariousness to the social feedback processes of the centers. 8. Some center personnel receive much more external feedback than others. The amount of feedback they receive does not seem to be related to their position within the center but to other factors, like personality, that were not within the scope of this study. This means that the receivers of less feedback are dependent on the receivers of more feedback for a complete picture of the effects of the services on the community. 9. Clinical staff at the mental health centers function as an important communications link and feedback channeling group. 10. Evaluation is a regular process within the mental health centers, involving all personnel. Goals are not always clear when comparisons between goals and actual performance are made, and the extent to which evaluators are aware of the effects of the services on the community varies. 11. Conflicts and disagreements are a part of the everyday organizational activities, and may or may not be resolved. Their role in the decision-making process is somewhat unclear, but, at a level where it does not seriously disrupt

center goal-attainment, conflict may be constructive at several points, such as in stimulating clarity, new ideas or solutions, productivity and defining problems.

From these findings certain strengths and possible problems in mental health centers emerge.

The mental health centers sampled in this study are very democratic organizations. They encourage collective input for decision-making. Goals and means are frequently assessed and evaluated in both formal and informal sessions, which results in an evolution of goals and means as perceived circumstances warrant. Feedback from center personnel on organizational and clinical issues is exchanged regularly and systematically, which should be important in preventing surprises due to a communication's defect. The Division of Mental Health is in regular contact with the centers. This should provide opportunity for a forum of exchange, coordination and regulation.

The feedback sources of the Executive Board are disproportionately limited, when compared to the weightiness of the decisions they are called upon to make. Their principle source of information about the centers is the Executive Directors. This may work fine under normal circumstances. But under extenuating ones, such as an Executive Director that is not a good information provider, serious problems could develop.

Mental health center internal feedback appears to be quite systematic. But, as has been pointed out earlier, the external feedback is not. Undoubtedly, a principle reason for this is that funds have not been available to support this kind of activity. Today, there is both

state and federal legislation or grants that require evaluations as a part of accountability. Accurate evaluations and maximum goal attainment can only be realized through the use of an instituted feedback system at all organizational levels. Regarding external feedback, this would include: follow-up systems, both short-term and long-term; regular informal discussions with a variety of community people; formal requests for feedback from community agencies as part of an exchange to assist them; adequacy studies, which feed back information on the fit of center services to the needs of the various groups within a catchment area.

The two theoretical questions in this study centered around the social feedback model. The data collected from the mental health centers indicated that the stages in organizational feedback processes need not follow each other in one fixed sequence as in a musical scale. The stages may in fact be thought of as being in a continuous state of process, not necessarily waiting for the next stage, and might profitably be shown as such in the schematic representation. Feedback in a self-regulating system is but one influence in the control process. The control process does not always include it, (particularly when feed-forward is employed) or may include it imperfectly.

An elaborated social regulation model has been suggested that includes both more traditional chains of decision-making and control (first goal setting, then means setting, implementation, effects on the environment, feedback gathering, evaluation and finally corrective action) and continuous process decision-making where goals and means are changed in response to environmental as well as feedback information. This situation

may be found especially in organizations where the goal-setters, the means-setters and the implementers are frequently the same people, as is the case in mental health centers. This elaborated social regulation model is both open and closed-loop. It is represented in Figure 17.

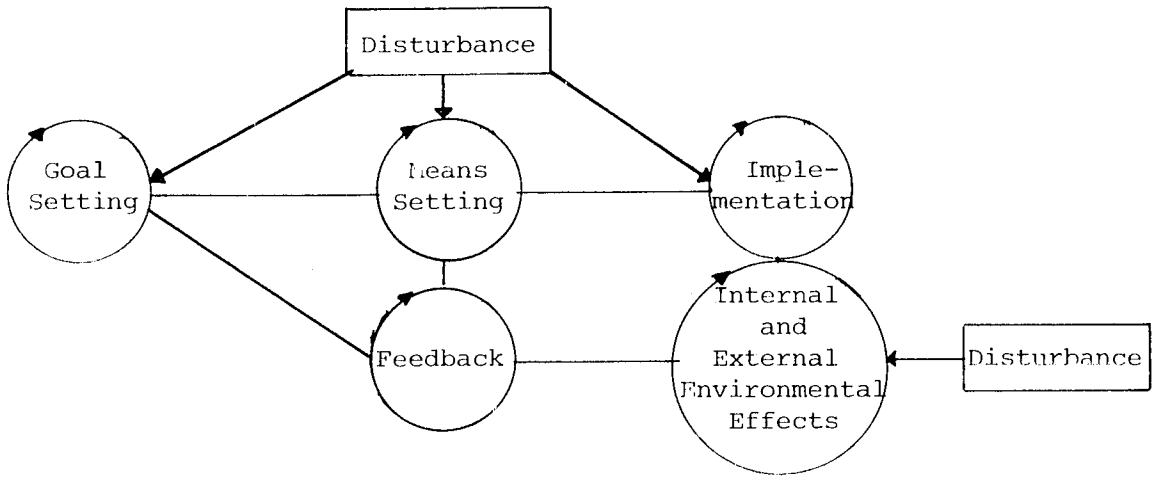

Figure 17. Elaborated Social Regulation Model

The elaboration is still in the form of a general model and may be applied to many settings. For specific application a diagramed scheme of the goal setting or the means-setting of any particular organization may be inserted within the appropriate circle in the model.

The present study of social feedback was conducted on a sample of mental health centers in New Hampshire. The sample was intentional rather than random to make it possible to research selected relationships. The descriptive findings from the sample data may not be identical in all respects to data that could be collected from the other centers in New Hampshire in another study, but they should be indicative of basic mental health center feedback and control processes. They should also apply to mental health organizations in other parts of the country. The

greater the variance of an organization from the sample organizations the greater the possible latitude in the trends one would find in the social feedback processes.

The elaborated social regulation model is general enough to be testable on any complex organization. It would be of great interest if this were done. Likewise the relationship between a collegial decision-making process and the continuous state of the stages in organizational self-regulation and control should be tested in various types of organizations. This would help to establish the degree of generalizability of the findings from this study. It would also be a validity check on the suggested model elaborations.

A process by definition is change. When studying processes one is looking at that which is changing. Mental health centers are systems of realtionships, acts, processes. These are always in a state of flux. It was suggested earlier that one doesn't step into the same stream once. And so, how long the findings of this study might be found useful is unknown, but surely limited. The Methodology chapter reviewed the limitations of this study relative to some difficulties with the interview schedule, the sample, the methodology. But the greatest limitation of all is probably time. In an attempt to be relevant we may always be playing catch-up.

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APPENDIX I

NEW HAMPSHIRE DIVISION OF MENTAL HEALTH

STANDARDS FOR COMMUNITY MENTAL HEALTH SERVICES

1. INTRODUCTION

New Hampshire Revised Statutes Annotated 126-B:11 provides that the Director of Mental Health shall: (a) promulgate rules and regulations governing eligibility of community mental health programs to receive state grants, prescribing standards for qualifications of personnel and quality of professional services; (b) review and evaluate local programs and make recommendations thereon to the board of directors; (c) provide consultative staff service to communities to assist in ascertaining local needs and in planning and establishing community mental health programs.

Standards offer guidelines to communities for the establishment and operation of mental health programs, help to ensure a minimum level of service quality for the public, and provide a base for program and administrative evaluation.

Standards should not be considered static; there must be a mechanism established to ensure continuing review for appropriate modifications based on experience, new knowledge, and other external developments which may affect community mental health facilities, services, personnel, or administration.

These standards evolve from and are consistent with (1) the federal community mental health centers act and the regulations relating thereto; (2) New Hampshire's community mental health act (RSA 126-B) and regulations relating thereto; (3) New Hampshire Division of Mental Health's Goals and Objectives and Plans.

Standards must be enforceable and enforced if effective accountability to the citizens of New Hampshire is to be ensured. Thus, the standards themselves and the procedures for their application cannot be separated. The standards will continue to be included in the legal agreement negotiated annually between the State of New Hampshire, through the Division of Mental Health, and each of the community mental health organizations receiving state grants-in-aid. Surveying for compliance is most effectively accomplished through four types of review: review of program data, review of services, review of records, and review of premises. All except the first will be undertaken through site visits.

Compliance with established standards will be a prerequisite for state funding through the Division of Mental Health.

Consultation services will be offered to community mental health agencies to help them remediate programs in non-compliance with standards; reasonable time limits will be set for meeting requirements. Loss of state funding will be imposed only after persistent non-compliance and only after the offending organization has been afforded full opportunity for rebuttal and reform.

II. ORGANIZATION

A. Eligible Organizations - Counties, towns, municipalities, and non-profit organizations in New Hampshire may be eligible for state grants-in-aid for community mental health programs if they meet the standards promulgated by the Division of Mental Health.

1. Board of Directors - Every city, county, or town, or non-profit corporation, establishing a community mental health services program shall establish a board of directors representative of the socio-economic, ethnic, and geographic characteristics of the population served; the membership of the board shall be as representative as possible of local health departments, medical societies, hospital boards, lay associations concerned with mental health as well as labor, business and civic groups and the general public.

   The Board of Directors shall:

   a. be responsible for the effective administration of its mental health programs;
   b. review and evaluate community mental health services and report thereon to the director of mental health and when indicated, the public, together with recommendations for additional services and facilities;
   c. recruit and promote local financial support for the programs from private sources such as community chests, business, industrial and private foundations, voluntary agencies and other lawful sources and promote public support for municipal and county appropriations;
   d. promote, arrange and implement working agreements with other social service agencies both public and private, and with other educational and judicial agencies;
   e. review the annual plan and budget and make recommendations thereon.

III. GOALS - OBJECTIVES - PROGRAMS

A. Each organization applying for state mental health funding must submit its application on the forms provided for this purpose to the Division of Mental Health by March 1 of each year. Each application shall include the program plans, anticipated revenue and expenditures and objectives of each program component for which state funds are sought.

   The objectives should be consistent with those defined in the Division of Mental Health's State Plan and "Goals and Objectives for Community Mental Health Services". Written objectives must show how the organization intends to meet the needs of the residents of its service area.

III. GOALS - OBJECTIVES - PROGRAMS (Continued)

B. Programs

Any one or a combination of the following services may qualify for a state grant (Program definitions are included as an addendum):

1. Outpatient services
2. Partial hospitalization services
3. Inpatient services
4. Consultation and Education
5. Emergency services
6. Rehabilitative services
7. Training
8. Research and evaluation
9. Planning
10. Specialized services

C. Clinical Services

1. Continuity of care

a. Any person eligible for treatment within any one component of the agency's service will also be eligible for treatment within any other component of service;
b. Any patient within any one element will be transferred to any other component whenever such a transfer is indicated by the patient's clinical needs;
c. Clinical information concerning a patient within one component shall be made available to those responsible for that patient's treatment within any other component;
d. Those responsible for a patient's care within one component should, when practicable, continue to care for that patient within any of the other components.

2. Clinical Records

a. Each agency shall develop and maintain a record of clinical information for each patient, to include the following; identifying data; admission and evaluation data; history; treatment plan; treatment course; termination and disposition information.
b. Clinical records shall be confidential, current and accurate. Except as provided by law, the written consent of the patient or his legal representative is required for release of clinical information. Records may be removed from the facility's jurisdiction and safekeeping only as provided by law.

IV. ADMINISTRATION

A. Personnel

1. Professional staff

a. The professional staff of a community mental health organization offering clinical services must include qualified personnel of at least the following professions: psychiatry, psychology and social work. The services of the various professional disciplines must be integrated through regular staff meetings and other conferences for the joint planning and evaluation of treatment.

b. A Professional Training - Experience Record for each professional staff member employed by the community mental health agency must be filed with the Division of Mental Health by the time of his employment, on forms designated by the Division. A Statement of Proposed Duties must accompany the Training - Experience Record for each staff member not qualified under one of the three disciplines listed above.

c. Minimum qualifications

1. Psychiatrist: Graduation from a medical school; license to practice medicine in N.H.; and 3 yrs. of approved psychiatric residency training.

2. Clinical Psychologist: Certification by the N.H. Bd. of Examiners in Psychology; and (a) Ph.D. in clinical psychology, or (b) a Master's Degree in psychology and 1 yr. of full time supervised experience as a member of a tri-discipline psychiatric team in a clinical setting.
NOTE: A psychologist who is not certified by the N.H. Bd. of Examiners in Psychology, but who either has a Ph.D. in Clinical Psychology or a Master's Degree in Psychology and 1 yr. of full time, supervised experience as a member of a tri-discipline, psychiatric team in a clinical setting will satisfy the minimum requirements, provided there is on the agency's staff a N.H. certified psychologist to provide supervision.

3. Psychologist Trainee: Clinical internship as part of a course of study in an accredited graduate psychology program and immediate supervision by a certified clinical psychologist.

4. Psychiatric Social Worker: A Master's Degree in social work.

5. Psychiatric Social Work Trainee: Field work placement as part of a course of study in an accredited graduate school of social work and immediate supervision by a graduate social worker.

IV. ADMINISTRATION (Continued)
Personnel

6. Psychiatric Nurse: A registered nurse with (a) a graduate degree in psychiatric nursing, or (b) one year's psychiatric nurse experience, including inservice training.

7. Other Professions: Minimum acceptable training and experience as established by N.H. State Law or by the respective state professional associations.

d. A board eligible or board certified psychiatrist must assume medical responsibility for the clinical diagnostic and treatment program of the agency. He must serve a minimum of one day a week or its equivalent to adequately fulfill this responsibility and to supervise the activities of the other professional disciplines.

2. Personnel policies

a. Each community mental health agency shall have written personnel policies which will cover at least the following: Recruitment and selection; job descriptions; hours of work; vacation, sick, and educational leave; holidays; insurance; grievance procedure; retirement, medical and other insurance; termination from employment.

b. Individual employment records shall be maintained by each community mental health agency and shall contain at least the following:

1) Current background information sufficient to justify the initial and continued employment of the individual in the position for which he was employed. Applicants for positions requiring a licensed person should be employed only after the facility has obtained verification of their licenses, their records of education and their references.

2) Current information relative to periodic work performance evaluations.

3. Director

a. Each community mental health agency shall have a director who is a qualified mental health professional. The director must have overall authority and responsibility for the operation of the agency and for the provision of a program which is responsive to the needs of the service area. (NOTE: Incumbents (as of 7/1/74) who are not "qualified mental health professionals" will be exempt from this requirement for present and future positions.)

IV. ADMINISTRATION (Continued)

B. Admission Policies

1. Each community mental health agency shall specify in writing and publicize its admission policies and procedures, and the range of diagnostic and treatment services it offers. Any and all appropriate measures shall be undertaken to ensure that the community at large is aware of the services offered by the agency.

2. Services may not be refused to any person because of his race, color, creed, or country of origin.

3. No one is to be excluded from service because of his inability to pay a fee.

C. FEES

1. A graduated fee scale, established by the Division of Mental Health, will be used for outpatient services.

2. Fee schedules for all other services must be approved by the Division of Mental Health.

D. CIVIL RIGHTS

1. All public informational brochures prepared by/for a community mental health agency must include a statement that the organization is an equal opportunity employer.

2. Annually, each community mental health agency will submit to the Division of Mental Health a statement as to the agency's continued compliance with Title VI of the Civil Rights Act of 1964.

3. Each community mental health agency will prominently display in its facility a statement of Title VI Compliance.

V. FISCAL MANAGEMENT

A. Accounting System

1. An accounting system shall be maintained which provides information that reflects the fiscal experience and current financial position of the agency. Such system shall be responsive to reporting requirements by the Division of Mental Health.

V. FISCAL MANAGEMENT (Continued)

B. Financial Reports

1. Each agency will submit to the Division of Mental Health, on forms designated by the Division, by the 15th day of October, January, and April, a report of revenue and expenditures for the preceding quarter of the fiscal year.

2. Each agency will arrange for an annual independent audit of its revenue and expenditures by a qualified accountant, and will submit a detailed report of the audit to the Division of Mental Health before each September 30th for the preceding fiscal year on forms provided by the Division of Mental Health.

C. Other Fiscal Policies

1. State funds may be applied to the salaries of professional personnel up to, but not exceeding, the maximum rates for comparable positions in the state government. Local revenue may, however, be applied to that portion of a salary in excess of the state government rate.

2. Any significant program or budget adjustments during the fiscal year will require prior approval by the Division of Mental Health.

VI. PHYSICAL QUARTERS

A. The community mental health agency quarters shall be structurally sound and shall meet the requirements of applicable federal, state, and local laws and regulations pertaining to physical safety, sanitation, adequacy of entry and exit capability, fire protection, and all other aspects of physical safety and serviceability.

B. Facilities housing patient services shall be comfortable and provide sufficient privacy to maintain confidentiality of communication between a patient and a staff member. They shall be easily identified and located, reasonably accessible and convenient to the community served.

C. In the interest of protecting confidentiality, every clinical record should be kept in a separate folder and all folders kept in a file, which should always be locked when not in active use.

VII. ADMINISTRATIVE STATISTICS AND REPORTS

A. Statistical data

1. Statistical data will be submitted monthly to the Division of Mental Health on forms designated by the Division, by specified dates, relating to the following:
    a. Professional staff
    b. Services rendered
    c. Movement of patients
    d. Characteristics of patients
    e. Community demand for services which the agency is unable to provide.

B. Annual progress reports

1. A progress report shall be submitted annually to the Division of Mental Health which will include the following information as a minimum:
    a. A statement of services rendered by the agency during the preceding year.
    b. A statement of the current status of liaison between the reporting agency and other health and welfare agencies in the service area and efforts planned to increase such liaison with particular reference to general hospitals, public health, welfare, and vocational rehabilitation agencies.
    c. A statement of goals, priorities, and objectives for the coming year.

VIII. EVALUATION

A. Each community mental health agency shall evaluate the effectiveness of its services at least annually. The results of such evaluations shall be incorporated with its application for state funds.

The fundamental questions which need to be answered are: (1) to what extent have program objectives been met; (2) at what cost; and (3) with what degree of satisfaction. The determination of the degree of attainment requires information provided by recipients of services, by agency representatives, by community representatives, and by data sources outside the community. Systematic follow-up activities should be part of an agency's program.

IX. AFFILIATED SERVICES AND AGREEMENTS

When an agency in receipt of state mental health funds has service agreements with other agencies, such arrangements shall be evidenced by written agreements between the separate organizations. A copy of each such affiliation agreement shall be filed with the Division of Mental Health at the time application is made for state funds.

SPH:rn
Revised:September 1, 1974

STANDARDS FOR COMMUNITY MENTAL HEALTH SERVICES

ADDENDUM

PROGRAM DEFINITIONS

1. Outpatient Services:

Services which enable individuals to obtain treatment for emotional, mental, or behavioral problems without disrupting the pattern of their daily lives. The usual procedure involves periodic visits of a relatively short duration.

Outpatient services shall include, but shall not be limited to, diagnostic evaluation, individual and/or group therapy, consultation, and rehabilitation. These services may also include research and therapeutic modalities such as crisis intervention, family therapy, and others that are adaptable to the community and the facility.

Outpatient services should be organized to provide for initial treatment within the immediate community, and provide continuity of care for patients released from an inpatient service or a partial hospitalization service.

Outpatient services staff may include, but need not be limited to, psychiatrists, psychologists, educators, social workers, nurses, public health administrators, para-professionals and community outreach personnel. The staff providing treatment and consultation shall be adequately trained in accordance with their designated disciplines and shall have appropriate supervision as indicated by the clinical director.

2. Partial Hospitalization Services:

A service whose primary purpose is to provide a planned program of milieu therapy and other treatment modalities. The service is designed for non-residential patients who spend only a part of a 24 hour period in the facility. Examples of partial hospitalization facilities are day hospitals and night hospitals.

Partial hospitalization services might include, but need not be limited to, full day or part day treatment, evening treatment, night treatment or weekend treatment.

There shall be a sufficient number of clinical staff and supporting personnel to effectively fulfill the stated objectives of the partial hospitalization services. Responsibility for the diagnosis and treatment of patients shall remain with the clinical director.

Members of the clinical staff may include, but need not be limited to, psychiatrists, psychologists, social workers, nurses, mental health workers and educators.

A partial hospitalization program shall be reasonably accessible to the community and be conveniently available by way of public or center arranged transportation.

There shall be at least one clinical employee present during the time that the partial hospitalization service is operating. This person may be aided by other individuals such as volunteers who are capable of carrying out the program as established by the center.

3. Inpatient Services:

These will provide short term care and treatment on a 24-hour-a-day basis, for persons with acute psychiatric illness.

The inpatient service shall provide an intensive treatment program in a therapeutic environment. The setting should be designed to aid in the patient's recovery, and treatment should be aimed at moving him from the inpatient service into another mental health service or into the community as soon as he is sufficiently improved.

The inpatient service shall be reasonably accessible and immediately available.

Inpatient facilities shall be structurally suitable to assure the patient of privacy when desirable, while at the same time encouraging therapeutic interaction between patients and staff members. Cheerful, open surroundings and pleasant furnishings are desirable. Wards should be kept small, probably seldom more than 24 beds of one to 4 bed units; the number of beds required should vary with the service area, patient population, and the manner in which other mental health services are used.

Inpatient services shall be under the direction of the clinical director. The service shall be staffed by personnel from the medical, nursing, psychological, social, rehabilitation, and other mental health disciplines who are trained to help restore the individual patient to his full capabilities.

There shall be at least one registered nurse on duty at all times and additional staff shall be on duty as needed. A psychiatrist shall be available to the inpatient service at all times.

4. Consultation and Education:

Consultation services are those furnished by qualified mental health personnel to professional persons in the community, such as non-psychiatric physicians and clergymen, to community agencies such as schools, public health departments, courts, police, probation, and welfare departments, and voluntary health, welfare, and recreation agencies concerning emotional problems of individuals with whom they deal. Educational services refer to in-service training and other mental health education for professional personnel, and the dissemmination of mental health information to the general public.

Consultation and education place emphasis on the prevention of emotional disturbance.

5. Emergency Services:

These refer to the availability on a 24-hour-a-day basis of crisis intervention services.

There are two major components of the emergency service; face to face contact and a crisis telephone service. The emergency service must provide face to face crisis intervention by mental health professionals or qualified mental health workers. In any event, there must be a mental health professional immediately available for consultation and direct service, as needed. There are several ways by which an agency may provide face to face crisis intervention. It may be provided in one or more facilities within the catchment area, through mobile crisis intervention teams, or through a combination of mechanisms.

Each emergency service should include a 24-hour-a-day crisis telephone service manned by mental health professionals or trained mental health workers. Such telephone service can provide the basic mechanism for the evaluation of the crisis and the determination of the steps necessary to ensure the rapid provision of appropriate care.

Whenever possible, one central service with a single telephone number should be established. This will provide for better continuity and coordination, will lessen the chances of "losing patients," and will maximize visibility. It may be necessary, however, to establish more than one telephone service when an agency serves a large geographical area made up of several small cities and towns. In either case, the telephone number or numbers should be clearly listed in the directory or directories serving the area.

When the telephone service is manned by non-professional mental health workers, there must be a mental health professional immediately available for consultation.

6. Rehabilitative Services:

Vocational, educational and social programs would aid those who need such care, including former hospital patients.

Rehabilitative services are designed to reduce the residual deficits of emotional disturbance and to facilitate the adjustment of patients in the community through a variety of vocational and social programs including, though not limited to, vocational testing, counseling, job placement, and other relevant group activites, as appropriate.

7. Training:

The purpose of the training service is to increase the job related mental health skills of all community mental health agency personnel through the provision of lectures, seminars, workshops, and other educational programs.

8. Research and Evaluation:

These include basic and applied research into mentally handicapping conditions, and program evaluation of services for the mentally disabled. Research and evaluation provides objective information regarding community needs and resources, the impact of service delivery, and the extent to which the community mental health agency is meeting its objectives and goals. It includes appropriate measurement, data collection, and analysis.

Program evaluation requires an explicit statement of objectives, the identification of methods of measuring the extent to which these objectives are fulfilled, and the implementation of procedures for taking measurements periodically.

9. Planning:

Planning refers to the process for assessing the community's mental health needs, developing objectives to meet those needs, and a proposal for comprehensive services, including program proposals, budget proposals, and a plan for evaluation.

10. Specialized Services:

These services are predicated upon the fact that they are specially designed

to meet the special needs of various particular segments of the population who otherwise cannot make optimal use of the center's regular services. Specialized services to particular segments of the population require, by and large, the same kinds of criteria as do other community mental health agency services.

SPH:gc

Rev. September 1, 1974

APPENDIX II

Interview Schedule for Administrators, Board Members, Advisory Board Members, Coordinator of Division of Mental Health

Introduction:
Position of interviewee:
Length of time position held:

1. Would you give me a general description of your role at the_____ Mental Health Center.

2.a. The various clinics across the state delegate the many clinic responsibilities in different ways. Could you tell me what your role is, if any, in the_____,_____,_____services regarding:

Name of service:

goal setting -

means setting -

execution of the program -

feedback (information relating to goals) gathering -

feedback communication -

assessment -

change -

2.b. What other groups, if any, play a role in the above?

2.c. What happens when goal-setters, means-setters, change-setters don't agree?

Interview Schedule for Administrators, etc. continued.

Name of service:

goal setting -

means setting -

execution of the program -

feedback gathering -

feedback communication -

assessment -

change -

Name of service:

goal setting -

means setting -

execution of the program -

feedback gathering -

feedback communication -

assessment -

change -

Interview schedule for Administrators, etc. continued.

3. Who are your sources of information about the clinic, specific services?

4. What role, if any, does the clerical staff play in:

goal setting -

means setting -

execution of the programs -

feedback gathering -

feedback communication -

assessment -

change -

APPENDIX III

Interview Schedule for Clerical Staff.

Introduction

Position:
Length of time position held:

1. Would you give me a general description of your role at the_____ Mental Health Center.

2. The various clinics across the state delegate the many clinic responsibilities in different ways. Could you tell me what your role is, if any, concerning:

   goal setting -

   means setting -

   execution of the programs -

   feedback (information relating to goals) gathering -

   feedback communication -

   assessment -

   change -

3. If you receive information about how a program or service is doing, how do you usually handle it?

4. Where or from whom do you receive such information?

APPENDIX IV

Interview Schedule for Mental Health Clinic Staff

Introduction

Staff member's position:
Service or services involved with:
Length of involvement with service:

1. Could you give me a brief description of what the staff in the_____ service are doing? (program activities)

2. What are the goals/objectives of this service?

   How are they specified? verbally___, in written form___

3.a. Who sets up these goals/objectives? What role does the administrator/ play in goal-setting?

3.b. What happens when the goals-setters don't agree?

4.a. Who decides on the means to achieve these goals/objectives? What role does the administrator/s play in means-setting?

4.b. What happens when the means-setters don't agree?

5. Discovering the effects of a service can be very difficult. To what extent do you feel you know what the effects of the_____service are? short term - actually not at all___,___ - long term
   to some extent___,___
   in large part___,___
   have complete knowledge___,___

6. What are the ways you have for finding out? a follow-up system?

7. Is there an opportunity for you to either formally and/or informally discuss these effects with your fellow service colleagues and to compare them with the goals? (specify the opportunity) with other colleagues? others? (side effects probe if necessary)

Staff Interview Schedule continued.

8. Are the goals of the service clearly enough defined that you can use them as a standard for comparing with the effects?

9. How much discrepancy, if any, is there between the goals of the service and actual accomplishment? none___, some___, a lot___, total___

10. Has there been any change in staff on the service during the last year?

11. How has this effected the service?

12. Has the service been changed in any way in the last year? goals? means? therapeutic means alterations?

13.a. Who decided on these changes?

13.b. What happens when the change-setters don't agree?

14. What agencies, organizations does the staff in the service come in contact with? What kind of feedback (information relating to goals), if any, do you get from each?

Agency	Oral	Written	Obs.	Formal	Inf.	Frequency	Inadeq.	Adeq.	Over.

Staff Interview Schedule Continued.

15. From which of the following other groups do you receive feedback?

Group	Oral	Written	Obs.	Formal	Inf.	Frequency	Inadeq.	Adeq.	Over.
Other staff outside service									
Administrators									
Board members									
Advisory Board members									
Div. of Mental Health									
Families of clients									
Grantees									
Political figures									
Client himself									
Other									

APPENDIX V

TABLE I

FEEDBACK SOURCES FOR ADMINISTRATIVE STAFF, MANCHESTER MENTAL HEALTH CENTER

INTERNAL SOURCES

1. administrative staff
2. clinical staff
3. clerical staff
4. other mental health centers
5. Division of Mental Health
6. Executive Board members

EXTERNAL SOURCES

1. visiting professionals, e.g. from HEW
2. staff from general hospitals
3. Child and Family Service
4. Probation Department
5. N.H. Program on Drug and Alcohol Abuse
6. Visiting Nurses Association
7. New Hampshire Hospital
8. clergy
9. private psychiatrists
10. private physicians
11. departments of Welfare
12. United Fund
13. patients
14. families of patients
15. legislators
16. local politicians
17. New Hampshire College
18. business community
19. funding sources, e.g. U.S. State Department
20. community people
21. Tenants Association
22. Housing Authority
23. agencies to which accountability reports are sent, e.g. NIMH, Board of Mayor and Alderman
24. Concentrated Employment
25. Office of Youth Services
26. lawyers
27. courts

APPENDIX V

TABLE II

FEEDBACK SOURCES FOR CLERICAL STAFF, MANCHESTER MENTAL HEALTH CENTER

INTERNAL SOURCES

1. clinical staff
2. administrative staff
3. other mental health centers

EXTERNAL SOURCES

1. private physicians
2. private psychologists and psychiatrists
3. departments of Welfare
4. Vocational Rehabilitation
5. Concentrated Employment
6. police
7. city agencies
8. patients
9. families of patients
10. Veterans Administration
11. New Hampshire Hospital
12. Parole officers
13. Probation officers
14. schools

APPENDIX V

TABLE III

INTERNAL FEEDBACK SOURCES

OUT-PATIENT STAFF, MANCHESTER MENTAL HEALTH CENTER

SOURCE	ORAL	WRITTEN	FORMAL	INFORMAL	INADEQUATE	ADEQUATE	OVERLOAD
staff							
A.B.C.D.E.F.	xxxxx		xxx	xxxxxx	xxx	xxxx	
	x						
G.H.I.J.K.	xxxxx	xxxxx	xxxx	xxxxx	xxx	xxxx	xx
administration							
A.B.C.D.E.F.	xxxxx		xxx	xxxxx		xxxx	
	x						
G.H.I.J.K.	xxxxx	xxxxxx	xxx	xxxxx	xxxxx	xxxx	xx
Board members							
G.H.I.	xxx		x	xxx	x	xx	
Div. of Men. Health							
D.F.H.J.K.	xxxxx	xx	xxx	xxxxx		xxxxxx	
clerical staff							
B.	x			x		x	
Caritas C.	x			x		x	
conference of men. health centers K.	x			x		x	
other men. health centers							
G.I.	x	xx	xx	x		xx	
other men. health centers							
A.B.	x	xx	xx	x		xx	

APPENDIX V

TABLE IV

EXTERNAL FEEDBACK SOURCES

OUT-PATIENT STAFF, MANCHESTER MENTAL HEALTH CENTER

SOURCE	ORAL	WRITTEN	FORMAL	INFORMAL	INADEQUATE	ADEQUATE	OVERLOAD
Easter Seals A.D.	x	x	x	x		x	
N.H. Hospital A.B.C.E.F.	xxxx	xxxx	xxxx	xxx			
G.I.J.K.	xxxx	xxxxx	xxxxx	xxxx	xxxx	xxxxx	x
welfare A.B.C.E.	xxxx	xxx	xxx	xxx		xxx	
	x						
F.G.H.I.K.	xxxx	xxx	xxxx	xxx	xxx	xxxx	xx
physicians A.	x	x	x	x		x	
schools A.C.D.E.	xxx		xxx	xxx			
F.G.H.I.	xxxx	xxxx	xxx	xxx	xxxxx	xxxxx	
V.N.A. A.C.E.G.J.K.	xxxxxx	xxxxx	xxxxxx	xxxx	xx	xxxxxx	
families A.B.C.	xxxxx			xxxxx	xxxx	xxxx	
D.E.F.G.H.							
I.J.K.	xxxxxx	xxx	xxxx	xxxxx	xxxx	xxxx	xxx
patient A.B.C.	xxxxx	xxx obs*	xxxx	xxx	xxx	xxxx	
D.E.F.G.H.		xxxxx					
I.J.K.	xxxxxx	xxxxxx	xxxx	xxxx	xxxx	xxxxx	xx
Office of Youth Services A.F.	xx	xx	x	xx		xx	
lawyers A.F.I.	xxx	xx	xx	xxx	xx	x	
Child & Family Service B.E.J.K.	xxxx	xx	xx	xxx		xxxx	
boarding home B.J.K.	xxx			xxx	xx	x	
general hospital staff B.C.E.	xxx		x	xx	x	xxx	

*obs. stands for observation

APPENDIX V

TABLE IV (Continued)

EXTERNAL FEEDBACK SOURCES

OUT-PATIENT STAFF, MANCHESTER MENTAL HEALTH CENTER

SOURCE	ORAL	WRITTEN	FORMAL	INFORMAL	INADEQUATE	ADEQUATE	OVERLOAD
politicians B.	x		x			x	
physicians B.E.F.G.I.	xxxxx	xxxx	xxxx	xxxx	xxx	xxxxx	
Voc. Rehab. C.E.F.G.	xxxx		xxx		xx		
H.I.J.K.	xxxx	xxx	xxx	xxxx	xxx	xxx	
Concentrated Employ. C.E.F.	xxx			xx		xxx	
G.I.J.K.	xxxx	xxx	xxx	xxx	xx	xxx	
Green House C.E.F.	xxx		x	xx	xx	x	
police C.I.J.	xxx	x	xx	xx	x	xx	
Man. Child Care Assoc. D.	x			x		x	
Elem. Guidance Serv. D.	x			x		x	
Convulsive Disorder D.		x	x			x	
clergy E.J.K.	xxx			xxx		xxx	
Youth Dev. Center E.F.	xx	xx	xx	x	x	x	
Cath. Charities E.J.	xx			xx		xx	
Day Care Center E.G.	xx		xx	x	x	x	
Neigh. Youth Core E.	x		x			x	
orphanages E.G.	xx		xx		x	x	

APPENDIX V

TABLE IV (Continued)

EXTERNAL FEEDBACK SOURCES

OUT-PATIENT STAFF, MANCHESTER MENTAL HEALTH CENTER

SOURCE	ORAL	WRITTEN	FORMAL	INFORMAL	INADEQUATE	ADEQUATE	OVERLOAD
Probation Dept. F.G.I.	xxx	xxx	xxx	xx	x	xx	
Dept. of Education F.	x		x			x	
Parole officers F.	x	x	x	x		x	
jails F.	x		x	x		x	
Odyssey House F.	x	x	x	x		x	
Marathon House F.	x		x			x	
private employers F.	x		x			x	
Neigh. Info. & Referral G.	x		x			x	
Off. of Men. Retard. G.	x	x	x			x	
collages I.	x			x		x	
drug treat. prog. J.	x			x		x	
P.O.D.A. J.	x		x	x		x	
other patients J.	x			x			
Social Security J.	x	x	x	x		x	
Family Planning K.	x		x	x		x	
Man. Housing Auth. K.	x		x	x		x	

APPENDIX V

TABLE V

INTERNAL FEEDBACK SOURCES

NIGHT SHIFT, MANCHESTER MENTAL HEALTH CENTER

SOURCE	ORAL	WRITTEN	FORMAL	INFORMAL	INADEQUATE	ADEQUATE	OVERLOAD
other staff A.B.C.D.	xxx	x	xx	xx	xxxx		
administration A.B.C.D.	xxxx	xx	xxx	xx	xxx		

APPENDIX V

TABLE VI

EXTERNAL FEEDBACK SOURCES

NIGHT SHIFT, MANCHESTER MENTAL HEALTH CENTER

SOURCE	ORAL	WRITTEN	FORMAL	INFORMAL	INADEQUATE	ADEQUATE	OVERLOAD
families B.D.	xx			xx		x	
client A.B.C.D.	xxxx	x	obs. x	xxxx	xx	x	
friends D.	x			x			
general hospital B.	x			x			
police B.	x			x			

APPENDIX V

TABLE VII

INTERNAL FEEDBACK SOURCES

IN-PATIENT STAFF, MANCHESTER MENTAL HEALTH CENTER

SOURCE	ORAL	WRITTEN	FORMAL	INFORMAL	INADEQUATE	ADEQUATE	OVERLOAD
staff A.B.C.	xxxx			xxxx	xxx	xxx	
D.E.F.G.	x						
H.I.J.	xxxx	xxxx	xxxxx	xxxxx	xxxx	xxxx	
administration	xxxx		xxxx	xxxx		xxxx	
A.B.C.D.E.	x						
F.G.H.I.J.	xxxxx	xxx	xxxxx	xxxx	xxxx	xxxx	
Caritas B.E.F.	xx			xx		xx	
other men. health centers D.I.	xx			xx		xx	

APPENDIX V

TABLE VIII

EXTERNAL FEEDBACK SOURCES

IN-PATIENT STAFF, MANCHESTER MENTAL HEALTH CENTER

SOURCE	ORAL	WRITTEN	FORMAL	INFORMAL	INADEQUATE	ADEQUATE	OVERLOAD
Welfare A.B.H.	xxx	x	x	xxx	x	xxx	
Concentrated Employ. A.B.C.E.	xxxx		x	xxxx	x	xxxx	
Voc. Rehab. A.B.F.	xxx	xxx	xxx	xxx	xx	x	
A.A. A.B.G.	xxx			xxx		xxx	
Prog. on Drug & Alco. A.	x			x		x	
N.H. Hos. A.D.E.G.I.	xxxxx	xxxxx	xxxxx	xxxxx	xx	xxxxx	
Philbrook Center A.		obs*x		x	x		
families A.B.D.	xxxx		xx	xxxx	xxx	xxxx	
E.F.G.	xx						
H.I.J.C.	xxxx	x	xxxxx	xxxxx	xxxx	xxxx	xxxx
patient A.B.D.	xxxx	obs.xxx	xxx	xxxxx	xxx	xxxxx	
E.F.G.	xx	xxx					
H.I.J.C.	xxxx	xxx xxx	xxx	xxxxx	xxxx	xxxxx	xxxxx
Catholic Charities B.D.	xx		x	x	x	x	
Greater Man. Child Care B.	x			x		x	
N.H. Assoc. for Blind B.	x			x		x	
Social Security B.	x	x	x	x		x	
Legal Aid B.	x			x	x	x	
Odyssey House B.	x	x	x	x	x	x	

APPENDIX V

TABLE VIII (Continued)

EXTERNAL FEEDBACK SOURCES

IN-PATIENT STAFF, MANCHESTER MENTAL HEALTH CENTER

SOURCE	ORAL	WRITTEN	FORMAL	INFORMAL	INADEQUATE	ADEQUATE	OVERLOAD
Child & Family Service B.D.H.J.I.	xxxxx	xx	xxxx	xx	x	xxxxx	
Planned Parenthood B.	x			x		x	
general hospital B.D.E.G.	xxx	obs.x xxxx	xxxx	xx	xxxx	xxx	x
Parents without Partners B.	x			x	x		
out-of-state men. health centers B.	x	x	x	x	x	x	
physicians B.J. G.H.	xxxx	xx	xxx	xxxx	xxxx	xxx	
police B.E.	xx		x	xx	x	xx	x
Learning Disabilities B.	x		x	x		x	
clergy B.G.	xx			xx		xx	
schools B.	x		x	x	x	x	
F.I.S.H. C.	x			x		x	
Green House D.	x		x			x	
private psychiatrists G.	x	x	x	x	x		

* obs. stands for observation

APPENDIX VI

TABLE XI

INTERNAL AND EXTERNAL FEEDBACK SOURCES

EXECUTIVE DIRECTOR, NORTH COUNTRY COMMUNITY SERVICES, INC.

INTERNAL SOURCES

1. clinical staff
2. clerical staff
3. Executive Board members
4. Division of Mental Health
5. Northern N.H. Mental Health System

EXTERNAL SOURCES

1. general hos. staff
2. Department of Welfare
3. Community Action
4. Vocational Rehab.
5. police
6. agencies representedby Board members, e.g. Probation Dept. clergy, schools
7. general hospital administration
8. Northern Counties Health Planning Council
9. businessmen and community people
10. acquaintances

APPENDIX VI

TABLE XII

INTERNAL AND EXTERNAL FEEDBACK SOURCES

CLERICAL STAFF, NORTH COUNTRY COMMUNITY SERVICES, INC.

INTERNAL SOURCES

1. clinical staff
2. administration
3. Executive Board members
4. Division of Mental Health
5. clerical personnel in N.N.H.M.H.S.

EXTERNAL SOURCES

1. community people
2. clients and former clients
3. families of clients

APPENDIX VI

TABLE XIII

INTERNAL FEEDBACK SOURCES

CLINICAL STAFF, NORTH COUNTRY COMMUNITY SERVICES, INC.

SOURCE	ORAL	WRITTEN	FORMAL	INFORMAL	INADEQUATE	ADEQUATE	OVERLOAD
staff A.B.C.D.	xxx			xxx		xxx	
E.F.G.	xxxx		xxxxx	xxxx	x	xxxx	
administration	xxx			xxx		xxx	
A.B.C.D.E.F.G.	xxxx		xx	xxxx	x	xxx	
Board members E.F.	xx			xx		xx	
Div. of Men. Health E.	x	x	x			x	
other men. health centers B.	x	x	x	x		x	

APPENDIX VI

TABLE XIV

EXTERNAL FEEDBACK SOURCES

CLINICAL STAFF, NORTH COUNTRY COMMUNITY SERVICES, INC.

SOURCE	ORAL	WRITTEN	FORMAL	INFORMAL	INADEQUATE	ADEQUATE	OVERLOAD
Welfare Dept.	xx			xxx		xxx	
A.B.C.D.E.F.G.	xxxxx	x	xx	xxxx	x	xxxx	x
schools A.B.D.	xxx			xxx	xx		
E.F.G.	xxx		x	xxx	xxx	xx	
Probation Dept. A.B.D.	xxx	xx	xx	xxx	x	xx	
physicians A.B.C.	xxx					xx	
D.E.F.	xxx	x	xxx	xxxx	xxx	xxx	
towns people A.C.E.F.	xxxx			xxxx	xx	xx	x
clergy A.B.C.F.	xxxx		x	xxx	xx	xxxx	
N.H. Hos. A.B.D.E.	xxxx	xxx	xxx	xxx	x	xxxx	
police B.D.E.	xxx			xxx		xxx	
Legal Aid B.	x			x		x	
gen. hos. staff B.E.	xx			xx	x	x	
lawyers B.E.	xx	x	x	xx	x	xx	
Vet. Admin. hos. B.	x			x	x		
families A.B.C.	xxx			xxx		xxx	
D.E.F.G.	xxx		xx	xxxx	xxxx	xxx	x
client B.C.D.	xxx	obs.xx		xxx		xxx	
E.F.G.	xxx	xx	xxx	xxx	xxxx	xxx	x
Soc. Security A.		x		x		x	
politicians B.	x			x		x	

APPENDIX VI

TABLE XIV (Continued)

EXTERNAL FEEDBACK SOURCES

CLINICAL STAFF, NORTH COUNTRY COMMUNITY SERVICES, INC.

SOURCE	ORAL	WRITTEN	FORMAL	INFORMAL	INADEQUATE	ADEQUATE	OVERLOAD
Alpha House B.	x			x		x	
Voc. Rehab. B.D.E.	xxx	x	x	xx	x	x	
Comm. Action B.D.E.	xxx		x	xx	x	xx	
Holiday Center C.D.F.	xxx			xxxx	x	xxx	
Retired Sr. Volunteer Prog. C.	x			x		x	
Prog. on Alco. & Drug Abuse D.	x		x	x		x	
Voc. Tech. D.	x	x	x	x		x	
Employ. Sec. E.	x			x		x	
Public Health Nurses E.	x			x		x	

APPENDIX VI

TABLE XV

INTERNAL AND EXTERNAL FEEDBACK SOURCES

EXECUTIVE BOARD, NORTH COUNTRY COMMUNITY SERVICES, INC.

INTERNAL SOURCES

1. Executive Director
2. other Board members
3. program directors at the center
4. clinical staff
5. Division of Mental Health

EXTERNAL SOURCES

1. newspapers
2. private physicians
3. schools
4. families of clients
5. clients
6. friends of clients
7. UNH Extension Nutrition contact
8. Council for Social Welfare
9. probationers
10. judge
11. lawyers
12. police
13. Department of Welfare
14. Vocational Rehabilitation
15. Alpha House
16. former executive director of White Mountains Community Services

APPENDIX VII

TABLE XVI

INTERNAL AND EXTERNAL FEEDBACK SOURCES

ADMINISTRATIVE STAFF, WHITE MOUNTAINS COMMUNITY SERVICES

INTERNAL SOURCES

1. clinical staff
2. clerical staff
3. Board members
4. Northern New Hampshire Mental Health System
5. other two clinics in N.N.H.M.H.S.

EXTERNAL SOURCES

1. business men
2. schools
3. Welfare Department
4. hospitals
5. clients
6. private physicians
7. lawyers
8. clergymen
9. private psychologists and psychiatrists

APPENDIX VII

TABLE XVII

INTERNAL AND EXTERNAL FEEDBACK SOURCES

CLERICAL STAFF, WHITE MOUNTAINS COMMUNITY SERVICES

INTERNAL SOURCES

1. clinical staff
2. administrative staff
3. Board members

EXTERNAL SOURCES

1. friends
2. relatives of clients
3. community people

APPENDIX VII

TABLE XVIII

INTERNAL FEEDBACK SOURCES

CLINICAL STAFF, WHITE MOUNTAIN COMMUNITY SERVICES

SOURCE	ORAL	WRITTEN	FORMAL	INFORMAL	INADEQUATE	ADEQUATE	OVERLOAD
staff A.B.C.D.	xxxx			xxx		xxxx	
E.F.G.	x						
H.I.	xxxx	xxxx	xxxx	xxxx	x	xxxx	
administration							
A.B.C.D.E.	xxxx		xx	xxx		xxx	
F.G.H.I.	xxxx	xx	xxx	xxx		xxxx	
Board mem	x						
B.C.E.F.G.	xxxx		xx	xxx	xx	xx	
Div. of Men. Health F.	x	x	x	x			
D.E.H.	xxx	xx	xx	xxx		xxx	
other men. health cen. H.C.	xx	xx	xx	x	x	xx	

APPENDIX VII

TABLE XIX

EXTERNAL FEEDBACK SOURCES

CLINICAL STAFF, WHITE MOUNTAINS COMMUNITY SERVICES

SOURCE	ORAL	WRITTEN	FORMAL	INFORMAL	INADEQUATE	ADEQUATE	OVERLOAD
Catholic Charities H.	x	x	x	x	x	x	
Prog. on Alcohol & Drug Abuse C.H.	xx		xx	x		xx	
Parole officers E.	x		x				
Home Health Agency H.C.	xx	x	xx			xx	
Voc. Rehab. H.	x	x	x		x		
Comm. In-Service Training E.	x		x			x	
Div. of the Blind H.	x		x			x	
Comm. Care Givers E.	x		x			x	
political figures H.D.E.	xxx			xxx		xx	x
families A.B.C.							
D.E.F.	xxxx	obs.x		xxxx		xxxx	
H.I.	xxxx	x	xx	xxxx	x	xxxx	
clients A.B.C.	xxxx	obs.x	xx	xxxx		xxx	
D.E.F.	x						
G.H.I.	xxxx	xxxx	xxx	xxxx	xx	xxxx	x
Crippled Child H.	x			x	x		
Div. of Welfare C.D.E.H.	xxxx		xx	xx	x	xxxx	

APPENDIX VII

TABLE XIX (Continued)

EXTERNAL FEEDBACK SOURCES

CLINICAL STAFF, WHITE MOUNTAINS COMMUNITY SERVICES

SOURCE	ORAL	WRITTEN	FORMAL	INFORMAL	INADEQUATE	ADEQUATE	OVERLOAD
clergy A.C. D.F.H.	xxxxx		xxxx	x	x	xxxx	
lawyers C.E.H.	xxx	x	xxx		x	xx	
Probation Dept. G.	x		x			x	
N.H. Hos. C.D.E.H.	xxxx	xxx	xxxx	xx	x	xxxx	
pub. health nurses D.G.I.	xxx			xx	xx	xx	
gen. hos. F.H.	xx	obs.x x	xx	x		xx	
schools A.C.D. E.H.	xx xxx	x	xxx	xx	xx	xxx	
Youth Dev. Center E.	x	x	x	x		x	
Glencliff H.	x		x			x	
House of Correc. A.	x		x			x	
Alpha House A.	x		x			x	
community people C.D.E.G.	xxxx		x	xxx	x	xxx	
physicians C.D.F.	xxx	obs.x	x	xx	x	xxx	
courts C.E.F.	xx	x	xxx		x	x	
Employ. Sec. C.	x		x			x	
Cath. Soc. Serv. D.	x			x		x	
police D.E.F.	xxx		xx	xx		xx	

APPENDIX VII

TABLE XX

INTERNAL AND EXTERNAL FEEDBACK SOURCES

EXECUTIVE BOARD, WHITE MOUNTAINS COMMUNITY SERVICES

INTERNAL SOURCES

1. clinical staff
2. administrative staff
3. other Board members

EXTERNAL SOURCES

1. clients
2. acquaintances
3. concerned citizens
4. volunteers from Franconia College
5. family members
6. clergymen
7. private physicians
8. friends
9. schools
10. police
11. lawyers

APPENDIX VIII

TABLE XXI

INTERNAL AND EXTERNAL FEEDBACK SOURCES

EXECUTIVE DIRECTOR, CARROLL COUNTY MENTAL HEALTH SERVICE, INC.

INTERNAL SOURCES

1. clinical staff
2. clerical staff
3. Board members
4. Northern New Hampshire Mental Health System
5. other mental health centers

EXTERNAL SOURCES

1. clergymen
2. legislators
3. County Commissioners
4. general hospital administration
5. schools
6. Welfare Department
7. N.H. Hospital
8. service clubs
9. community people
10. police
11. lawyers
12. county agencies

APPENDIX VIII

TABLE XXII

INTERNAL AND EXTERNAL FEEDBACK SOURCES

CLERICAL STAFF, CARROLL COUNTY MENTAL HEALTH SERVICE, INC.

INTERNAL SOURCES

1. administrator
2. clinical staff
3. Division of Mental Health

EXTERNAL SOURCES

1. clients
2. families of clients
3. community people
4. agencies

APPENDIX VIII

TABLE XXIII

INTERNAL FEEDBACK SOURCES

CLINICAL STAFF, CARROLL COUNTY MENTAL HEALTH SERVICE, INC.

SOURCE	ORAL	WRITTEN	FORMAL	INFORMAL	INADEQUATE	ADEQUATE	OVERLOAD
Staff A.B.C.D.	xxxx		xxx	xxx		xxxx	
E.F.G.H.	xxxx	xxxxx	xxxx	xxxx	x	xxxx	x
administrator	xxx		xxx			xxx	
A.B.C.D.E.F.G.	xxxx	xxxxx	xxx	xxxx	x	xxx	
Board mem.	xxx						
B.C.D.E.G.	xx	x	xxx	xxxx	xxx	xx	x
clerical staff D.	x			x		x	
Div. of Men. Health D.E.G.H.	xx						
F.A.C.	xxxxx	xx	xxxxx	xxxxx	xxxx	xxxxxx	xx
Development Center D.	x		x	x		x	
other men. health centers A.C.G.H.	xxx	xxx	xxxx	x		xxxx	

APPENDIX VIII

TABLE XXIV

EXTERNAL FEEDBACK SOURCES

CLINICAL STAFF, CARROLL COUNTY MENTAL HEALTH SERVICE, INC.

SOURCE	ORAL	WRITTEN	FORMAL	INFORMAL	INADEQUATE	ADEQUATE	OVERLOAD
Carroll County Home A.	x			x			x
schools A.B.C.	xxx						
D.G.H.	xxx	xx	xxxxx	xxx		xxxxx	x
N.H. Hos. A.B. C.F.G.	xxxx	xxxx	xxxxx	x	xx	xxxx	x
gen. hos. A.B.C.D.	xxxx	x	xxxx	xx	xx	xx	
physicians A.C.	xxx						
D.E.F.G.H.	xxxx	xxx	xxxxx	xxxxx	xxxxx	xxxx	xxx
clergy C.F.G.H.	xxxx		xxx	xx	xxx	xxx	x
friends of clients A.	x		x	x		x	
Homemaker Home Health Agency A.D.F.	xxxx		xxx	xxxx		xxx	x
Public Health nurses A.B.C.	xx		x	xx		xx	
lawyers A.F.	xx	xx	xx	x	x	x	
grantees C.		x	x		x		
politicians B.C.D.F.	xxxx	x	xx	xxx	xxx	x	x
client A.B.C.D.	xxxx	obs.				xx	
E.F.G.H.	xxxx x	xxxx	xxxxx	xxxxx	xxx	xxxx	x
police C.D.E.F.	xxxx		x	xxxx		xxxx	x
courts A.C.	x	x	x			x	
Probation C.	x	x	x	x		x	

APPENDIX VIII

TABLE XXIV (Continued)

EXTERNAL FEEDBACK SOURCES

CLINICAL STAFF, CARROLL COUNTY MENTAL HEALTH SERVICE, INC.

SOURCE	ORAL	WRITTEN	FORMAL	INFORMAL	INADEQUATE	ADEQUATE	OVERLOAD
Prog. on Alco. & Drug Abuse C.	x		x			x	
Head Start C.	x		x			x	
county jail C.	x		x			x	
Vista C.	x		x				x
Child & Youth Clinic C.F.	xx			xx		xx	
community people C.D.	xx			xx		x	x
V.N. Assoc. D.F.	xx	x	x	xx		xx	x
employers D.F.G.	xxx		x	xx		xxx	
druggists E.	x			x		x	
families A.B.	xxxx			xxx		xxx	
C.D.E.F.G.H.	xxxx		xxx	xxxx	xxx	xxx	x

APPENDIX VIII

TABLE XXV

INTERNAL AND EXTERNAL FEEDBACK SOURCES

EXECUTIVE BOARD, CARROLL COUNTY MENTAL HEALTH SERVICE, INC.

INTERNAL SOURCES

1. administration
2. staff
3. Northern New Hampshire Mental Health System

EXTERNAL SOURCES

1. service organizations
2. school nurse and teachers
3. physicians
4. 1972 survey
5. business people
6. Welfare Department

APPENDIX IX

TABLE XXVI

INTERNAL AND EXTERNAL FEEDBACK SOURCES

ASSISTANT DIRECTOR OF MENTAL HEALTH

INTERNAL SOURCES

1. Division of Mental Health staff
2. administrators of mental health centers
3. statistics
4. annual program reports, financial reports
5. peer consultation
6. center visits
7. Executive Boards

EXTERNAL SOURCES

1. clients and families of clients served by mental health centers
2. general public

APPENDIX IX

TABLE XXVII

INTERNAL AND EXTERNAL FEEDBACK SOURCES

COORDINATOR FOR COMMUNITY MENTAL HEALTH SERVICES

INTERNAL SOURCES

1. administrators of mental health centers
2. mental health center staffs
3. Division of Mental Health staff
4. statistics

EXTERNAL SOURCES

1. community agencies like Vocational Rehabilitation, schools, Program on Drug and Slcohol Abuse, welfare, Youth Services, Program on the Aged
2. general public

APPENDIX X

Tentative interview schedule for control center members who are not action output personnel (Board members, advisory group members, Division of Mental Health coordinator, administrators)

(introduction)

You are/were involved with the_____project/service?

1. What is/was the Board's, your, Division's role in that service?

2. Have you personally followed the effects of the service? made assessments?

3. Have you been involved in any changes in the service? How have they taken place?

4. What or who has/have been your source(s) of information about the service?

5. Are there other sources you could use?

APPENDIX XI

Tentative interview questions for action output personnel from the pre-test clinic, schedule used for In-Patient unit.

(following the introduction) You were/are involved in the_____ project/operation/service.

1. Could you give me a brief description of what people did/are doing in the service?

2. What were/are the goals/objectives for that service? (beyond vague generalities, note consistency of responses)

3. Who (individuals, groups) set up the goals/objectives?

4. Who decided on the means? (note if the same as goal setters, role of Division of Mental Health, names of non-action output goal setters, means setters)

5. Do you feel you know what some (most) of the effects of the service are yes___, no___

6. How did you, are you finding out?

7. Is there an opportunity for you to discuss these effects with your fellow service colleagues? With other colleagues? Other goal setters? Others?

8. Have procedures been set up for comparing the effects of the service with the original goals? How much discrepancy is there between goals and performance?

9. Has there been anychange in personnel on the service during the last year? Change in Board members? etc?

10. How has this effected the service?

11. Has the service been changed in any way within the last year?

12. Who decided on these changes? Individual, group, joint decision?

13. What has been the role of other staff in the service?
    Board members?
    the Administration?
    the Division of Mental Health?
    the public?
    other agencies or organizations? schools?
    political pressure?
    families of cliental?
    grantees?
    clients?

APPENDIX XII

Interview schedule used for Depot staff

Introduction:
Position of interviewee, service involved with:
Length of employment:

1. Could you give me a brief description of what the staff in the_____ service are doing?

2. What are the goals/objectives of this service?

3. Who sets up these goals/objectives?

4. Who decides on the means?

5. Do you feel you know what some of the effects of the service are?

6. What ways do you have of finding out?

7. Is there an opportunity for you to discuss these effects with your fellow colleagues? with other Tri-County colleagues?

8. Do you think there is much of a discrepancy between goals and performance?

9. Have procedures been set up for comparing the effects of the service with the goals?

10. Is there any kind of follow-up system?

11. Has there been any change in personnel in the unit during the past year? change in Board members?

12. How has this effected the unit?

13. Has the service been changed in any way during the past year?

14. Who decided on these changes?

15. What has been the role of the following groups in the service:
    a. other staff
    b. administration
    c. Advisory Board
    d. Executive Board
    e. the public
    f. Department of Mental Health
    g. other agencies, organizations
    h. families of clients
    i. grantees, funding sources
    j. political pressure
    k. clients

APPENDIX XIII

New Hampshire Division of Mental Health
105 Pleasant Street
Concord, New Hampshire

Community Mental Health Program

Statement of Goals

The Community Mental Health Goals for New Hampshire remain essentially the same as originally established in July, 1965. There were slight revisions in 1966 and again in 1968 based on progress which had been made toward the original goals.

This 1971 Statement of Goals does, however, provide a somewhat more specific direction for the allocation of State and Federal Community Mental Health funds through the establishment of a system of priorities.

The Problem

Nationwide neglect of the mentally ill was the disclosure made in ACTION FOR MENTAL HEALTH, the final report of the Joint Commission on Mental Illness and Mental Health, released in 1961. Mental illness and mental retardation cause more suffering, waste more of our human resources and constitute more financial drain on the public treasury and individual families than any other single condition.

Mental illness remains the Number One health problem in New Hampshire as well as in the entire country. More hospital beds are occupied by the mentally ill than by persons with all other types of illnesses and disabilities combined, including cancer, heart diesase, tuberculosis, and every other killing and crippling disease. In addition, at least 50% of all the medical and surgical cases treated by private doctors and hospitals have a mental illness complication. At least one person in every ten has some form of mental or emotional illness which needs psychiatric treatment.

Both the admission and readmission rates to New Hampshire Hospital have risen steadily over the years. As of 1968, New Hampshire had the fifth highest state hospital readmission rate in the country, and the eighth highest percentage increase in first admissions between 1966 and 1968; the fifth highest increase in elderly persons in state hospitals (only five states had any increase); the fifth lowest decrease in resident patients.

Our rates of crime, divorce, public welfare recipients, drug abuse, and other types of social problems continue to rise.

The Goal

A significant attack on these problems will necessitate a statewide mental health system which combines adequate resources at the local community level with the residential facilities and services of the New Hampshire Hospital.

A concerted drive must be made at the local community level to prevent mental illness and to treat and rehabilitate those persons who have become mentally ill. This is "Community Mental

Health". The goals of community mental health are: 1) to reduce the numbers of people requiring care and treatment in the state institutions; 2) to keep families together; 3) to keep the breadwinner on his job; 4) to make and keep the mentally handicapped productive citizens, contributing to society; 5) to prevent the need for public financial dependency; 6) to prevent suicides; 7) to prevent crime; 8) to prevent drug addiction; 9) to prevent separation and divorce.

The President's Joint Commission on Mental Illness and Mental Health pointed up the lack or inadequacy of appropriate service, research and training programs, and recommended community services as a means of prevention and treatment to avoid long term institutionalization.

Long Range Objectives

In 1963, on the basis of the Joint Commission's findings and recommendations, President Kennedy called for a "bold new approach" to meet the needs of the mentally ill and the mentally retarded through community based programs incorporating prevention, treatment and rehabilitation. Specifically, he proposed the development of regional mental health centers throughout the nation which would offer comprehensive services at the community level. He estimated that through the operation of such centers the state mental hospital population would be reduced by 50% "within a decade or two".

In October, 1963, Congress passed a bill which became Title II of Public Law 88-164, "The Community Mental Health Centers Act of 1963", authorizing federal appropriations to aid in financing construction of comprehensive community mental health centers. Under this Act, grants are made to the states, supporting from one-third to two-thirds of the construction costs, on the basis of state population and financial need. Subsequent amendments to this Act provide for federal grants for the initial cost of professional and technical personnel of community mental health centers. An eligible community mental health center can receive staffing grants over a period of eight years for the new services to be provided by the center; grants are made on a declining basis, from 80% (90% in poverty areas) of the costs for the first two years to 30% (70% in poverty areas) for the final year.

The following are the essential elements of a comprehensive community mental health center according to the provisions of the Act:

1. Inpatient services;
2. Outpatient services;
3. Partial hospitalization services, such as day care, night care, weekend care;
4. Emergency services 24 hours a day to be available within at least one of the first listed services;
5. Consultation and educational services available to community agencies and professional personnel.

The Comprehensive Community Mental Health Centers Act marks the beginning of a new era in the treatment of the mentally ill. In a comprehensive center, a patient will be able to receive the kind of treatment he needs, when he needs it, in the familiar environment of his own community. The trend toward emphasizing prevention - oriented mental health services has also contributed to the center concept. These services primarily consist of consultation to, and education for, "the guardians of mental health", such as teachers, physicians, clergymen, welfare caseworkers,

public health nurses, and police and probation officers.

New Hampshire's Plan, dated 1969, for Community Mental Health Center, which has been approved by the Federal Government, calls for the establishment of nine comprehensive mental health centers in the State of which the present fifteen community mental health agencies will be part. One center - at Hanover - is already in operation. The second - already approved for federal funding - will be built in Manchester.

Within existing and anticipated federal, state, and local financial resources, one or two new centers should become operational during each biennium until the goal of nine centers has been reached.

The development of a network of comprehensive mental health centers in New Hampshire depends on two components: (1) the appropriation of additional State funds to aid local communities in both the construction and staffing of centers; (2) the interest and participation in the planning of these centers by citizens throughout the State. Since there already exists in the State a number of community based and community supported outpatient mental health clinics, it would seem both reasonable and logical that these facilities should become the nuclei for comprehensive community mental health programs. Each of these agencies has substantial local support and interest through a citizen Board, fund raising, public relations and educational activities.

The long range goal is for local communities to assume responsibility for the care and treatment of the mentally ill as they do now for the physically ill. This plan will be implemented through the provision of inpatient psychiatric treatment in local general hospitals, and day treatment programs in addition to the present outpatient mental health clinics.

The New Hampshire Hospital will continue to be the major residential treatment facility in New Hampshire for both the acute and chronic mentally ill and even when the State is adequately covered by the regional comprehensive mental health centers, the New Hampshire Hospital will remain the only facility in the State for long term (beyond 3 - 4 weeks) hospitalization - it will provide the essential back-up to the local, comprehensive mental health services.

To provide adequately for the needs of the mentally ill, the community mental health services and the New Hampshire Hospital must be combined into a single mental health system. Under such a system, no person would be admitted to the New Hampshire Hospital unti he has been screened by the local mental health center and every patient leaving New Hampshire Hospital would be referred to his local mental health center for follow-up care.

Short Term Objectives

New Hampshire has taken only the first short step toward the long range goal of a network of comprehensive community mental health centers.

In New Hampshire, as in most of the other states, the Legislature has offered a financial incentive to local communities to develop mental health services. Small numbers of dedicated and interested citizens in all sections of the state have responded to their state government's encouragement by taking the initiative in establishing local porgrams of mental health services for the residents in their respective areas.

At present, there are fifteen voluntary, non-profit community mental health organizations

in New Hampshire which receive State grants-in-aid. Eleven of these are mental health clinics which offer diagnostic and treatment services on an outpatient basis to emotionally disturbed and mentally ill children and adults, and consultation and education for other professionals and for the general public. A twelfth agency, the Dartmouth-Hitchcock Mental Health Center, offers, in addition to outpatient services, short-term inpatient treatment, a day treatment program, 24 hour-a-day emergency services and consultation, education, and training. Another agency, Opportunity House, is a halfway house which offers a therapeutic, supervised, residential experience to patients leaving New Hampshire Hospital who are not yet ready for independent living, and to others as an alternative to hospitalization. Another agency, Child and Family Services of New Hampshire, provides specialized psychiatric consultation and education to other professionals and lay persons in regard to foster home care of children, adoptions, and in particular, the ever increasing problem of illegitimacy. The fifteenth agency is the Manchester Association for Retarded Children, which provides a variety of services to mentally retarded children and their parents.

All persons in the State now have access to outpatient mental health clinical services. Even though no new clinics are required, to make these services easily accessible, part-time branch offices of existing clinics should be established at several locations, including Exeter, New London, Peterborough and Woodsville.

The functioning community mental health clinics will be encouraged to extend services to the elderly as well as the young, to the mentally retarded as well as the emotionally disturbed, to the severly mentally ill as well as the psychoneurotic, and to the post-hospital patient as well as the person who has never been hospitalized. Further expansion of clinic services are needed to better meet the needs of persons with drug problems, the courts, the schools, day care centers, and to further reduce, if not eliminate, waiting lists for service.

Priorities of Need

In striving toward these objectives, systematic planning and coordination at the State level through selection of priorities will give direction to New Hampshire's community mental health program.

A. Although services of prevention are of great importance, at this point in time in New Hampshire, the top priority need is for the rehabilitation of the seriously mentally ill. New Hampshire has one of the highest State Hospital admission and readmission rates in the country and one of the lowest rates of decreasing State Hospital population.

This objective can be effectively met through the following measures at the community level:

1. The community mental health clinics should assume full responsibility for the follow-up treatment of patients returning to the community from the New Hampshire Hospital thereby eventually eliminating the need for the Hospital's traveling aftercare clinics.

The success of this approach has been demonstrated by two of the community clinics, North Country Community Services at Berlin and the White Mountain Community Services at Littleton; the hospital readmission rate from the service areas of those clinics has declined significantly since they have assumed responsibility for the treatment of patients returning from the Hospital to their respective

service areas. In contrast to the New Hampshire Hospital's aftercare clinics, the services of the community mental health clinics are available to them in their own community on a full time basis.

2. Social rehabilitation centers, such as Holiday Center in Berlin, should be established at population centers throughout the State offering the post-hospital patient an opportunity to socialize with other people and develop and maintain self confidence. Social isolation is one of the major factors leading to the readmission of persons to the State Hospital.

3. Additional halfway houses for the mentally ill, such as Opportunity House in Concord, should be established in the State. Many patients cannot go directly from the hospital to independent living and adjust satisfactorily. Some require a transitional, supervised, group, living situation as an intermediate step back into the community. For others, the halfway house provides a more acceptable and satisfactory alternative to hospitalization when a structured, therapeutic residential setting is required.

4. Further expansion of the Family Care Program within the Office of the Director of Mental Health is required. The first two years' operation of this program has successfully demonstrated its effectiveness in helping patients, particularly those who have chronic illnesses and have had lengthy hospitalizations, to adjust satisfactorily outside the institutions (new Hampshire Hospital and Laconia State School and Training Center). At one-third the cost of institutionalization, family care provides the patient with close supervision in a private family home as a necessary intermediate step toward independent living (some, however, may never be able to attain independent living).

B. The second priority need is to make the outpatient clinical diagnostic and treatment services readily available and easily accessible. To meet this need, waiting lists for service must be eliminated and outreach programs should be considered - to put the services where the people in need are located.

C. The third priority need for community mental services relates to the prevention of mental illness, emotional disturbance, and behavioral problems of children and youth. To meet this need, expansion of consultation services to schools, day care centers, the courts, and other professional groups is required.

D. The fourth priority relates to the increasingly serious problem of drug abuse. Additional clinical services of the community mental health clinics need to be provided to complement and supplement (not duplicate) those provided by other outpatient and residential programs.

E. The fifth priority need is for the increased availability of outpatient clinical services by the community mental health clinics for the mentally retarded and counseling for their parents.

F. The sixth priority need is in the area of geriatrics. Statistics as well as a local study of the mental needs of the elderly have clearly indicated that our mental health agencies have not responded adequately to the mental health needs of the elderly. New and different approaches by out community mental health organizations are needed to effectively meet this problem.

G. The final priority - the long range goal - is for the development of short-term inpatient psychiatric services in local, general hospitals, for day treatment programs, and 24 hour-a-day emergency services - to complete the requirements for comprehensive community mental health centers.

Allocation of all State and Federal community mental health funds not otherwise earmarked and not required for maintenance of the present level of services will be based on the program priorities set forth in this Statement with consideration also given to certain other criteria: 1) population to be served, 2) local fund raising efforts. Obviously, the more people there are in a given area, the bigger the job to be done and the more money which will be required to do it. Recognition should also be given to local fund raising efforts as an incentive to continue and improve those efforts.

Evaluation

To evaluate progress toward the State's community mental health goals and objectives, professional and statistical capabilities will be required in the Office of the Director of Mental Health greater than are now available.

SPH/rc

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APPENDIX XIV

There is a considerable body of literature that deals with the field of cybernetics and the concept of feedback. Norbert Wiener's books[1] are, of course, the classics. When pursuing the field of social feedback, as distinguished from all the other areas where feedback is applied, one finds a great deal of introductory material in the literature of systems theory and organizational behavior.[2] Much of this material outlines the basic principles and functions of organizational feedback. As our present interest is in the specific nature of social feedback processes, we shall review, first of all, what this literature has contributed to describing these feedback processes.

Karl Deutsch, in his book, The Nerves of Government, points out that the cybernetics perspective, when applied to organizations of all kinds, "represents a shift in the center of interest from drives to steering, and from instincts to systems of decisions, regulation and control, including the noncyclical aspects of such systems."[3] Social feedback,

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[1]Norbert Wiener, Cybernetics, New York, John Wiley and Sons, Inc., 1949 and The Human Uses of Human Beings, Boston, Houghton Mifflin Co., 1950.

[2]See C. West Churchman, The Design of Inquiring Systems, New York, Basic Books, Inc., 1971; Michel Crozier, The Bureaucratic Phenomenon, Chicago, Univeristy of Chicago Press, 1964; Peter Blau and W.R. Scott, Formal Organizations, San Francisco, Chandler, 1962; Joseph A. Litterer, The Analysis of Organizations, New York, John Wiley and Sons, Inc., 1965; Walter Buckley (ed.), Modern Systems Research for the Behavioral Scientist, Chicago, Aldine Publishing Co., 1968; Rosco Carzo, Jr. and John N. Yanoeizas, Formal Organizations, a Systems Approach, Homewood, Ill., The Dorsey Press, 1967; J. Eugene Haas and Thomas E. Drabek, Complex Organizations, New York, McMillan Co., 1973, and Daniel Katz and Robert L. Kahn, The Social Psychology of Organizations, New York, John Wiley and Sons, Inc., 1966. These are selected, useful sources chosen from a much larger body of systems and organizations material.

[3]Karl W. Deutsch, The Nerves of Government, London, Collier-Macmillan, Lts., 1963, p. 76.

he contends, may be of three kinds: goal-seeking, which is new external data that feeds back into the organization whose operating channels remain unchanged; learning, the feeding back of external data for the changing of the operating channels; and the feedback which is internal data and is analogous to what is called consciousness. The adaptability or "learning capacity of any .... organization, that is, the range of its effective internal arrangements, can .... be measured to some extent by the number and kinds of its uncommitted resources,"[4] or reassignable resources it holds, such as man-power and physical facilities. "Any network whose operating rules can be modified by feedback processes is subject to internal conflict between its established working preferences and the impact of new information."[5] But, conflict or not, systems must be able to respond to information by further changes in their own position or behavior to be able to approach a goal.

Duetsch writes that there are four quantitative factors in a feedback process that, in principle, can be measured and thus used to evaluate the efficiency of a feedback process. These factors are: 1. the load, referring to the extent and speed of changes in the position of the target relative to the goal-seeking system, 2. the lag or amount of time between the reception of information concerning the position of the target and the undertaking of action to obtain the objectives, 3. the gain, which is the amount of actual change in behavior that results, and 4. the lead or the distance between the most recent information on the position of a target and the accurately predicted future position of the moving target. These four factors serve to return an organization

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[4]Karl W. Deutsch, The Nerves of Government, London, Collier-Macmillan, Ltd., 1963, p. 96.
[5]Ibid. p. 95.

to the path of reaching its goal. This feedback is corrective or negative feedback, as in servo-mechanisms, like the simple thermostat. Some feedback may be termed positive, for it functions to reinforce or amplify the behavior of the organization. Unchecked, this could result in, first, a maximum level of organizational performance, then a type of overkill, perhaps system breakdown or exhaustion. Controlled positive feedback may have the consequence of bringing about changes in the organizational goals themselves. In this case the organization is a continuing decision system.

Herbert Thelen, in Dynamics of Groups at Work,[6] makes several observations about the principle of steering by consequences. He notes that purposes or objectives must be clearly seen so that consequences can be appraised. The actions of a group have consequences for other groups and therefore groups need to be classified according to a communications schedule. Questions concerning what sort of information should be reported to which groups and which groups are in a position to collect useful feedback become important and vital to establishing a functional communications network.

John Dorsey defines the word administration as decision-making.[7] In "Feedback in Administration",[8] Keith Warner notes that feedback is necessary for rational decision-making. It is an essential ingredient of an administrative climate attuned to attaining organizational objectives. Yet, administrations at all levels in an organization must make decisions

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[6]Herbert A. Thelen, Dynamics of Groups at Work, Chicago, University of Chicago Press, 1954.

[7]John T. Dorsey, "A Communication Model for Administration", Administrative Science Quarterly, Vol. 2, June 1957, p. 307.

[8]Keith W. Warner, "Feedback in Administration", Journal of Cooperative Extension, Vol. V. Spring, 1967, p. 35-46.

without having adequate information about the consequences of these decisions. This results in what Warner terms, leadership by quesswork, especially in organizations with relatively intangible goals. The more intangible the goals the more acute is the problem of feedback. Feedback "refers to the measurement of the consequences of the organization's activity and the communicating of the resulting information back to those responsible for making decisions which guide that activity."[9] This makes feedback an integral part of evaluation. In "A Critique of Evaluation", Frank Alexander writes that "it is not always possible or desirable to wait for an extensive study to produce better data."[10] And so administrators must and/or do decide and evaluate on the basis of less than adequate feedback.

Later on in his article on feedback in administration Warner explains that, "administration is concerned with 1. attaining organizational professed goals, and 2. maintaining and building the organization and its programs."[11] Feedback concerning four areas is therefore necessary, as is represented in the table below.

	Areas of Feedback Information	
Kinds of Information Needed	Goal Attainment	Organizational Maintenance
1. Degree of Accomplishment		
2. Degree that the Means are Being Implemented		

[9]Keith W. Warner, "Feedback in Administration", Journal of Cooperative Extension, Vol. V. Spring, 1967, p. 35-46.
[10]Frank D. Alexander, "A Critique of Evaluation", Journal of Cooperative Extension, Vol III. Winter, 1965, p. 212.
[11]Warner, op.cit. p. 40.

This feedback should be adequate along the dimensions of completeness, frequency, and reliability and validity. Reliability takes into account distortion and misapplication of information. The utility of feedback mechanisms must be judged at least somewhat independently of what decision makers do with the results.

"Feedback or communications loops originate primarily from key status positions", writes Alvin Bertrand.[12] Occasionally lower level positions originate messages, but the likelihood of such messages reaching top level positions and completing a loop is low"[13] because of backstops of intervening positions. This becomes a major problem in bureaucratic structures where corrections get delayed until stresses are very large. Bertrand notes that "internal feedback loops are inherent in the nature of intramural roles. Every status position in a group has an evaluator role that is a reciprocal to every other position in the group and is articulated whenever any type of behavior is manifest within the group. This evaluation leads to the activation of sanctioning roles, which account for the continual phenomena of self-regulating characteristics of higher level adaptive systems. It is also closely related to stresses and strains and the process of social control."[14]

Joseph Litterer devotes a section of The Analysis of Organizations[15] to a consideration of control processes and systems. Controls, he writes, refers to directivity and integration of effort, and has three phases: precontrol or preventing certain action, current control and post control

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[12]Alvin L. Bertrand, Social Organizations, Philadelphia, F.A. Davis Co., 1972, p. 120.
[13]Ibid, p. 120.
[14]Ibid, p. 143.
[15]Joseph A. Litterer, The Analysis of Organizations, New York, John Wiley and Sons, Inc., 1965.

or evaluation. Intermittent drives within an organization, such as economy drives, are evidence of bad management for they indicate that control is not regular and effective enough, not self-regulating enough. Deficient control may be related to an incomplete control system or feedback process, to delays between performance and feedback on that performance, or to communication distortions through poor channels or noncongruent, nonsupportive, noninterlocking goals.

In New Patterns of Management, Rensis Likert points out that delays and lags in feedback can be dealt with by shortening the feedback cycles.[16] This may be accomplished by means of regular measurement of the intervening variables thus allowing for continuous information flow, for controlled changes and experimentation. In this way undesirable developments might be prevented. The quality of decisions within an organization is directly related to the quality of that organizations feedback. Shortened feedback cycles may be an important key to improving feedback quality.

Delays are but one of the difficulties that may arise in the feedback process, as discussed by Rosco Carzo and John Yanoeizas in their book, Formal Organization, A Systems Approach.[17] They note that distortion of messages, bias, and noise cause erroneous information to be carried in feedback loops. Further, the actual performance situation may be disguised, leading to inaccurate feedback, 'because of .... (the) numerous sources of noise or random behavior and due to .... (the) often lengthy time delays between cause and effect."[18] Discontinuities in a feedback system may be related to varying abilities of component parts to process messages.

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[16] Rensis Likert, New Patterns of Management, New York, McGraw-Hill Book Co., Inc., 1961.

[17] Rosco Carzo, Jr. and John N. Yanoeizas, Formal Organization, A Systems Approach, Homewood, Ill., Richard D. Irvin, Inc. and The Dorsey Press, 1967.

[18] Ibid, p. 381.

Feedback messages may enter a system at a rate or quantity that the system is not prepared to handle. This is referred to as overload. J.G. Miller, in an article entitled, "Information Input, Overload, and Psychopathology",[19] analyses the reactions to overload. These reactions include: 1. omission, 2. error, 3. queing or delaying during periods of peak load in the hope of catching up during lulls, 4. filtering, 5. approximation or cutting categories of discrimination, 6. employing multiple channels, as in decentralization, and 7. escaping from the task. In an earlier article, appearing in 1955, Miller made some observations about negative feedback, and wrote: "When a system's negative feedback discontinues, its steady state vanishes, and at the same time its boundary disappears and the system terminates."[20]

Miller is one of numerous authors to write about the negative entrophy or disorganization arresting function of negative feedback. Kenneth Berrier concludes that "the consequences of feedback (negative) is to maintain a relatively steady rate of systems operations in spite of external variations. Systems controlled by feedback have a higher probability of survival."[21] In The Social Psychology of Organizations, Katz and Kahn devote space to such a consideration, and continue with an explanation of the relationship of the steady state and dynamic homeostasis in open systems.[22] They are oriented towards explaining the persistance or organizations. Not only does negative feedback function

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[19] J.G. Miller, "Information Input, Overload, and Psychopathology", American Journal of Psychiatry, no. 116, p. 695-704.

[20] J.G. Miller, "Toward a general theory for the behavioral sciences", American Psychologist, no. 10, p. 513.

[21] Kenneth F. Ferrier, General and Social Systems, New Brunswick, N.J., Rutgers University Press, 1968, p. 47.

[22] Daniel Katz and Robert L. Kahn, The Social Psychology of Organizations, New York, John Wiley and Sons, Inc., 1966.

to preserve the organization, but also, a type of feedback they refer to as operational feedback, acts to provide routine control over operations and is similar to the functions of servo-mechanisms with their continuous monitoring and adjusting. Katz and Kahn point out the importance of certain characteristics of feedback loops. They mention: the size of the loop, the nature of the circuit - repetitious vs modification in the circuit, the feedback or closure character (not open to change), the efficiency of the communication nets and the fit between the communications circuit and the systemic functioning.

"Control as an Organizational Process" by Haberstroh is another work that focuses on organizational maintenance.[23] Haberstroh writes of how an output can be maintained in some state in the face of disrupting external forces. Feedback on the deviation of the output from equilibrium is received by the organization and is used to measure the continual state of goal achievement. These goals as well as the performance are continually changing, consciously or unconsciously. "Goal formation is influenced by the intentions of the individual participants and by the environmental constraints under which they operate. Both can be sources of conflict. Stable patterns of organization is in part a process of conflict resolution. The necessity of reducing conflict to manageable bounds tends to direct the organization's efforts toward a small number of goals and a small number of means, relative to the number of alternatives that might be conceivable."[24]

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[23]Chadwick J. Haberstroh, "Control as an Organizational Process", Some Theories of Organization. The Dorsey Press, 1966.
[24]Ibid, p.

Along the same lines, Herbert Simon expresses doubt that decisions are directed toward achieving a single organizational goal.[25] Rather, decisions are concerned with discovering courses of action that satisfy a whole set of constraints. The set is the goal of the action, and involves a network of decision-making processes.

Goal attainment is maximized where goal displacement is minimal, according to Keith Warner and Eugene Havens.[26] Goal displacement is minimal where goals are tangible. With low goal tangibility, attainment may be high by keeping tangible goals directed towards the central intangible ones.

And Peter Nokes points out what many observers of feedback have noted, that feedback is essential to a successful attainment of goals.[27] Where feedback is inadequate or, alternatively, ignored, the end result for both individuals and institutions is failure, which may in turn lead to some form of disintegration. He adds that autistic thinking and a tendency to neglect the need for feedback are to be found in the conduct of certain social agencies. This results in imperfect contact with reality. This tendency to ignore feedback may be understood by realizing that if one feels in control of a situation, one may choose to ignore feedback or dispense with accurate information, feeling that such information is unnecessary.

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[25] Herbert A. Simon, "The Concept of Organizational Goal", Administrative Science Quarterly, Vol. 9, no. 1, June 1964, p. 1-22.

[26] W. Keith Warner and A. Eugene Havens, "Goal Displacement and the Intangibility of Organizational Goals", Administrative Science Quarterly, Vol. 12, no. 4, March 1968, p. 539-555.

[27] Peter Nokes, "Feedback as an Explanatory Device in the Study of Certain Interpersonal and Institutional Processes", Human Relations, Vol. 14, no. 4, Nov. 1961, p. 381-387.

These authors each add insights to the nature of feedback processes. They point out that feedback is categorizable, as in negative, positive, operational, goal-seeking, learning feedback, and they indicate many things about the functions of these types of feedback. They mention the importance of organizational adaptability, the relationship of quality decision-making to efficient feedback channels, numerous problems that can exist in the communication of feedback information and in the communications systems itself, and explain several of the influences upon goal-setting and goal realization. A suggestion is made that feedback is quantifiable, that it has several dimensions, like completeness, frequency, reliability, and must be studied in terms of the timing of the feedback relative to the performance it is concerned with.

All of this material is applicable to most any type of social organization. Which means that it is intended to be generalized, descriptive, and explanatory material. It is not intended to distinguish among feedback processes of varying types of organizations, (though Deutsch points out the application of cybernetics principles to the study of government, and Nokes notes that certain social agencies may have a feedback neglect tendency). At this generalized level the various writings are aimed at the similarities and commonalities of organizational feedback processes, and not at their differences and divergences. Deutsch writes that "cybernetics suggests that all organizations are alike in certain fundamental characteristics and that every organization is held together by communication".[28] The literature is not specific

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[28]Op. cit. Deutsch, p. 77.

enough to be down to the level of differences. It is general to the point of de-emphasizing the degree of complexity of organizational self-regulation. In terms of application, this material is at a level of both abstraction and one-sided focus that may make it difficult for operating organizations or their consultants to find useful.

This is not a criticism of what has been done, but rather a statement pointing out what still remains to be done in the light of the limitations to what has been accomplished.

With few exceptions, the literature on feedback processes is complementary and not contradictory. Perhaps the one significant area of divergence lies in the nature of the assumptions the various authors make about the degree of dynamics of the cybernetics perspective. Buckley has a good review of the search for social system models in Sociology and Modern Systems Theory.[29] He points out the strengths and the deficiencies of earlier models, including the ridgidness and limitations of structural-functionalism and equilibrium models. And yet, several authors of cybernetics, a process model, continue to make homeostasis and negative entrophy central in their thinking in a manner that is biological and Spencerian in its flavor. The elaborating, deviating functions of feedback (morphogensis in Buckley's work) are infrequently mentioned. Many authors never consider conflict in feedback processes or the conflicting consequences of feedback. They may note possible problems in feedback loops, but the assumption seems to be made that these can be identified and resolved, and that feedback is essentially a cooperative, constructive, organization-maintaining process. This would dismiss

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[29]Walter Buckley, Sociology and Modern Systems Theory, Englewood Cliffs, N.J., Prentice-Hall, Inc. 1967.

the thought that conflict may be a regular and necessary product of feedback, and in some form or at some level of intensity may not be disposable.