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Leadership dependency in outpatient mental health partnership clinics in Massachusetts: 1976-1980.

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LEADERSHIP DEPENDENCY IN OUTPATIENT MENTAL HEALTH PARTNERSHIP CLINICS IN MASSACHUSETTS: 1976-1980

A Dissertation Presented
By
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ABSTRACT

Leadership Dependency in Outpatient Mental Health
Partnership Clinics in Massachusetts
1976 - 1980

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This dissertation introduces and then tests a leadership dependency model that explains the mechanism through which change originating in the external environment enters an organization. This mechanism is termed the leadership dependency characteristics of the top leadership position in the organization. It refers to the origin of financial resources that support the top leadership position. The resource dependency theory proposed by Pfeffer and Salancik (1978) provided the conceptual framework that led to the development of this model.

The model was tested in twelve mental health clinics in Massachusetts and data were collected based upon interviews with the clinic directors. Nine organizational change variables were identified and quantified in order to measure the clinics' response to changes in the external environment. Data were drawn from two years separated by a

five year interval. Qualitative and quantitative analyses were performed on the coded data to explore the relationships among the variables and to determine whether or not the extent of leadership dependency of the clinic director position was correlated with the degree of change in the organization.

The results show significant correlations between the degree of leadership dependency as determined by the funding source of the top leadership position and the amount of organizational change that occurred between the beginning and end of the five year period. In addition, the qualitatative analysis addressed the problems that emerged in attempting to make operational the concept of organization change in the mental health clinics that comprised the sample.

The results are discussed in terms of their implications for research in the area of organizations and their environments, and in terms of their importance to policy makers who seek to introduce change into complex social organizations. The limitations of this study are discussed, and suggestions for future research on this subject are identified.

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CHAPTER I

THE STATEMENT OF THE PROBLEM

This study was an attempt to resolve the following problem: What, if any, is the relationship between the accountability characteristics of the top leadership position in an organization, and that organization's response to environmental changes? Because this study focussed attention on the leadership situation and on the external network of relationships that is connected to the leadership position, its approach to the problem was significantly different from that of the mainstream of leadership model which tends to focus on the behavior of the individual who occupies the position in relationship to the behavior of the group that is being led (Blake & Mouton, 1964; Fiedler, 1967; Blanchard & Hershey, 1977).

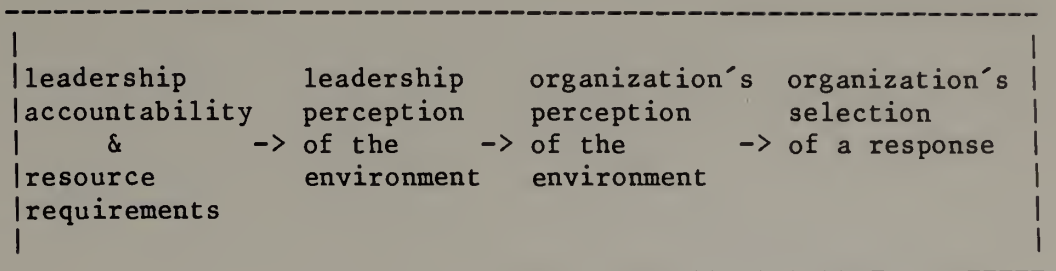
This study attempted to do two things. First it developed a model that explained the way in which change entered an organization through the top leadership position. Second, it conducted an empirical test of this model, making the model operational and testing it in twelve partnership mental health clinics in Massachusetts.

The model hypothesized that the extent of the accountability requirements attached to the top leadership position in an organization is determined by the origin of the resources that support that position, and the strength of that accountability relationship will be the primary determinant of the way the top leadership position perceives the environment. While not explicitly tested in the empirical research portion of this dissertation, the model developed in this study assumes that the top leadership person's perception of and response to the environment will, in turn be a primary determinant of the way in which the organization responds to its external environment.

Because organizational perception of the environment has been shown to be the most important predictor of the organization's selection of a response to changes in the external environment (Aldrich, 1978; Pfeffer & Salancik, 1979), the model tested in this study links leadership position resource and accountability requirements with organizational response to environmental change. This relationship, which is termed the leadership dependency model, can be diagrammed as follows.

FIGURE 1

THE LEADERSHIP DEPENDENCY MODEL



The relationship can be stated as follows:

> The accountability and resource requirements of the top leadership position in the organization will predict that organization's selection of a response to environmentally initiated change.

Hypotheses related to this relationship were tested in a field study of selected Department of Mental Health Outpatient Clinics in Massachusetts. The study is described in Chapter III of this dissertation.

Significance of the Study

This study has both theoretical and practical significance. Because it develops and tests a model that explains the relationship between the environment,

leadership, and organizational response to environmental change, it addresses a significant gap in the literature. In addition, by testing the model in mental health outpatient clinics, the study will be able to provide insight into the problems many states are encountering as they attempt to comply with legally mandated deinstitutionalization efforts by expanding an existing community mental health system to serve high risk deinstitutionalized clients.

Theoretical Significance of the Leadership Dependency Model

The leadership dependency model posits that the resource and accountability requirements attached to the top leadership position in an organization, will determine that organization's response to environmental changes.

The original question that was asked, which began the process leading to the development of the leadership dependency model was:

> To what extent are the decisions of top leadership affected by factors in the organization's external environment?

My interest was in the leadership situation and the external network of relationships in which the leadership position was imbedded, rather than on th psycho-social characteristics of the individual who occupied the position (e.g. Blake & Mouton, 1964; Fiedler, 1967; Hershey & Blanchard, 1977).

Leadership theorists such as Blake & Mouton, (1964) and Hershey & Blanchard, (1977) tend to focus on assessment of the proportion of relationship versus task concern found in the leader's behavior, and then evaluate the effectiveness of the leader based on a match between the behavior and the employee's leadership needs.

Leadership position, on the other hand, refers to the situation in which the leader finds her or himself. It is defined by the job description, and is independent of the personality traits of the person who occupies that position (unless, of course, the occupant takes active steps to alter the job description).

The researcher had a personal reason for selecting the leadership position as opposed to leadership traits as a topic for this study. As a manager of a mental health center, there was a need to make a large number of organizational decisions that seemed to be completely dictated by the environment. Most of the major

organizational changes that were initiated during my leadership tenure had less to do with my own personal style and preferences than with the implacable demands from the organization's environment, and the need to maintain a viable organization in the face of those demands. This discovery led to a search for literature that examined the leadership situation, and its impact on leadership decision-making. It appeared that most of the leadership theorists tended to overestimate the amount of power wielded by organizational leaders, and attributed both the success and the problems of an organization to the leadership style, ignoring the effect of both structural variables and environmental factors (Gamson & Scotch, 1964; Pfeffer & Salancik, 1978).

Sociological researchers, on the other hand, were willing to look at the organizational situation, but their focus on technological requirements and environmental uncertainties led them to downplay the role of leadership (Thompson, 1967; Lieberson & O'Connor, 1972).

While there was a clear need evidenced in the literature to examine leadership decision-making in the context of the organization's external environment, leadership behavior was not the focus interest. Rather, the focus was on the impact of the behavior of the person in the top leadership position, as influenced by the external

environment, on organizational response to the environment. Consequently, the second research question was:

> How does leadership moderate environmental influences on the organization?

With the exception of the study of public finance agencies conducted by Meyer in 1978, and the Pfeffer & Salancik's study of administrative succession in 1980, there were no empirical tests anywhere in the literature that attempted to identify the relationship between changes in the external environment, leadership, and organizational response to environmental change.

Both of these studies were critical to the development of the leadership dependency model because they both asked <u>how</u> leadership moderates environmental impact on the organization. In light of the environmental interests of these researchers, it is not surprising that they focussed on the contextual aspects of leadership, rather than on leadership behavior per se.

Meyers study was significant because it examined the effect of leadership position dependency/autonomy on organizational change over time. Pfeffer & Salancik's (1980) test of administrative succession, on the other hand, tested the hypothesis that change in top leadership in response to reduced profits is more likely to occur in

organizations that are not owner managed. The model that they were attempting to test in this case was whether administrative succession was a method of organizational adaptation to environmental change. They hypothesized that environmental change produced changes in the power of subgroups both inside and outside the organization, such that subgroups better able to access critical resources (or who appear better able), will gain power and select a new leader who represents that powerful subgroup's expertise and interests (Pfeffer & Salancik, 1978).

In both studies the central hypothesis is based on the concept of resource dependency which states that organization or individual A has power over organization or individual B to the extent that A owns or controls resources that B considers critical to her or his survival and therefore must acquire from A (Blau, 1964; Pfeffer & Salancik, 1978).

Because the leadership dependence model grew out of the concept of resource dependency, this study owes a great deal to those first attempts to empirically test the model by applying it to leadership in organizations.

Measuring organizational response to environmental impact by measuring change in net profits (Pfeffer & Salancik, 1981) or changes in basic structural variables

over time (Meyers, 1975), can aid in determining whether or not leadership moderates environmental impact, but it does not tell us how the process actually works. While Meyer's (1978) model of leadership autonomy does attempt to explain the process further, it is questionable whether or not his empirical study tests his model since the changes in his structural variables are not explicitly linked to environmental changes.

Pfeffer & Salancik's study (1981) is a better test of their model since it can be assumed that in the private sector maximizing profit is always an optimal response to environmental change. But the mechanism of administrative succession would have been revealed in greater detail had they included an in depth examination of some of their cases in order to identify the specific organizational changes that accompanied administrative succession. This is necessary if the leadership change is to be viewed as anything more than symbolic in nature.

The literature on boundary spanning, on the other hand, does explore the various kinds of boundary roles that link the organization with the external environment, such as the role of fundraisers, professional associations, and interlocking boards of directors (March & Simon, 1958; Thompson, 1967; Hodge & Anthony, 1969). This literature hypothesizes that a relationship exists among organizational

adaptability, environmental contingencies, and boundary roles (Aldrich, 1977; Hage & Aiken, 1970). However, there are few empirical studies that actually test the relationship between boundary roles and organizational change.

In addition, the boundary spanning literature tends to underestimate the importance of the boundary spanning role of top leadership, and therefore has a tendency to treat all boundary spanning activities throughout the organization as of equal importance in organizational decision-making.

The question that is still only partially answered by any of the existing studies is <u>how</u> does leadership moderate environmental influences on an organization? In order to answer this question it was necessary to pair an environmental change with a specific organizational response. If it were possible to identify variations in organizational response to the same environmental change, and then determine that these variations were consistent with certain kinds of leadership situations, it would provide significant insight into the question of how the leadership situation moderates environmental influence on an organization.

The question of how the environment impacts on the organization is addressed in this study by employing leadership accountability as the critical variable. The concept of leadership accountability as it is defined in this study is based on the assumption that when leadership is highly accountable to external environmental factors, e.g. to representatives from interest groups in the organization's community, it is significantly more likely that the needs of that external interest group will be transmitted through the leadership into the organization and will, therefore, result in organizational change. Thus, in this example, the amount of environmentally initiated change to enter the organization is determined by the degree of leadership accountability to whomever or whatever in the environment is initiating the change.

Because most of the literature examining the relationship between environmental characteristics and changes in organizational structure is theoretical (Emery & Trist, 1965; Thompson, 1967; Terreberry, 1968; Hannan & Freeman, 1977; Aldrich, 1979), it does not address the problem of why some organizations are more likely to change in response to environmental stimuli while others are passive, or actively fight change (Stinchcombe, 1965; Aldrich, 1979; Whetten, 1980). The problem is further complicated because while the factors that <u>impede</u>

organizational adaptation to external environmental change are fairly well documented (Stinchcombe, 1965; Aldrich, 1979), there is little agreement about which organizational structural variables facilitate change (Whetten, 1980).

Rather than simply asking, why do some organizations actively embrace environmental change while others actively fight it, this study asks:

> What role do the leadership accountability characteristics play in determining whether or not an organization actively embraces or actively fights change, or selects a response somewhere in the middle of those two extremes?

The Need for Measurements

It was necessary to make operational organizational response to environmental change in order to measure variations in response based on whether or not the leadership position could be described as dependent or independent in respect to the external environment. In reviewing the literature on organizational change, it became apparent that this was another area in which the theories far outweighed the empirical research.

One theorist created a terminology that distinguished between changes in the organizational population, and changes in the way those forces affect the organizational

population (Heinz, 1976). Stinchcombe (1965) offers the following hypothesis to account for the persistence of organizational forms over time: (1) the existing organizational form is most efficient; or (2) there are powerful vested interests or a strongly legitimated ideological position; or (3) there are no competitors.

Other theorists hypothesize that inter-organizational relationships and government regulation are two important external actors that contribute to organizational resistance to change (Aldrich, 1979); or that powerful elite political or social groups can protect an organization so that it does not have to change in response to environmental changes (Alker, Buckley & Burns, 1976).

All of these theorists, while acknowledging the importance of an environmental perspective, tend to treat environmental and organizational change as two <u>parallel</u> processes, and therefore only infer the connection between the two. This approach does little to illustrate the process of environmental impact. To put the matter more concretely, we still do not know <u>how</u> environmental change enters an organization - where is the doorway and what does it look like? And how is passage through this theoretical doorway controlled by the characteristics of the leadership position?

This study looks at the leadership position's extent of accountability to external environmental groups; hypothesizing that the extent of externally initiated impetus to change that enters the organization is determined as a result of the accountability requirements attached to the top leadership position.

In order to establish measurable organizational response categories the researcher borrowed concepts from the literature on manager response to change. Two different typologies captured the same range of change responses using different terminology. The more dramatic terminology could be found in the work of Miles, Snow & Pfeffer (1974), who characterized managers as either domain defenders, staunchly repelling all change initiatives originating in the external environment; reluctant reactors, slowly acknowledging the need to change and grudgingly making necessary organizational adjustments; anxious analyzers, worriedly scanning the environment in an attempt to anticipate change before it has a detrimental impact on the organization, and enthusiastic prospectors, seeking out change and leaping to make organizational adjustments in order to take maximum advantage of the positive advantages that go to those organization's that occupy the forefront of change movements. Whetten's (1980) more prosaic characterizations described managers as either generating, reacting to,

defending against, or preventing change.

One of the few researchers to identify organization, in addition to individual, response to external change, Brewer (1980) points out that organizational response ranges from "overt" hostility at one end of the spectrum to "full scale acceptance" at the opposite end, with "do nothing" in the middle. He acknowledges that "the personalities, interests, and training of individuals have identifiable impacts on the innovation process" (page 345), and cites a study that found that a primary factor underlying bureaucratic innovation was the influence of a key, ideologically committed leader (Downs, 1976).

The current researcher synthesized and adapted these typologies to create the four categories of organizational strategic response to change. The creation of a typology describing organization strategic response to change addressed another gap in the literature by providing a means to link changes in the environment with changes in the organization. The application of cross lag correlation measures to identify the amount of time between environmental change and an organizational strategic response could address questions about the factors that influence the amount of time it takes an organization to assimilate an environmental change, and the impact of time lag on organizational survival and success.

In summary, this study is theoretically significant for a number of reasons. First, its contextual approach to leadership links leadership with the external environment, and thereby provides a new perspective on the study of leadership and decision-making. Second, its creation of the concept of organizational strategic response makes it possible to measure the impact of the environment on the organization, and therefore provides the researcher with opportunities to test models that hypothesize why the same environmental change can have a different impact on different organizations within the same population. And third, this model opens up a third option for empirical research (which is not tested in this particular study) in which a researcher can do cross lag correlations to determine the amount of time that elapses between a specific environmental change and its impact on different organizations within a population. This could be valuable in determining relationships between the time it takes for an organization to assimilate an organizational change, and other factors such as leadership and organizational survival.

Finally, the social control aspect of government regulation is based on the belief that government regulatory policy on public and private industry can influence those industries to achieve desirable social goals (Galbraith,

1976). Insight into the affect of environment on organizational structure and goals will aid policy makers as they attempt to design regulations that will compel those organizations to achieve desired social goals.

An understanding of the process of organizational adaptation to external environmental change has implications for all organizations, but has particular importance for organizations in the human services sector. The American public's sympathy for the less fortunate has often conflicted with its reluctance to allocate the resources necessary to actually help. The result has been an uneven social service system characterized by "enormous budgets, dispersed responsibility, fragmented funding and structure of service agencies, and inaccessible, unresponsive, discontinuous service delivery" (Weiss, 1980, p. 2).

In addition, social service organizations are created in response to specific human service needs. These needs change over time, requiring that those organizations created to address those needs change as well. Yet a basic characteristic for all organizations is the tendency to resist change (Stinchcombe, 1965; Weick, 1969; Hannan & Freeman, 1977). There is a critical need to change the social service delivery system in the United States. Providers of human services are faced with a taxpayers' rebellion that is at least partially fueled by the general

public's disenchantment with the inefficiency of an uncoordinated and inaccessible social service system that has resisted all efforts to change.

Insight into even one small segment of the social service system - delivery of outpatient mental health services through the mechanism of the private, non-profit corporation, is a step toward understanding how to make the social service system more flexible.

Because the type of organizational strategic response selected by a clinic had a major impact on the development of mental health services in the clinic's service area, insight into the factors that influenced the strategic responses utilized by each clinic could be important for mental health policy planning.

The implications for the field of mental health are even more significant as the drive toward a community based system for high risk clients leads to an increasing reliance on the private non-profit sector for actual service delivery. These private non-profits are quasi-autonomous agencies, and they are controlled only through the mechanism of the formal contract with the funding agency. It therefore becomes important for state and national governments as well as other funding agencies (as a significant element of the environment of that focal

organization) to understand how they impact on the organization, and how changes in their own goals and structure are likely to impact on the organization that they depend upon for actual service delivery.

Limitations of the Study

There are a number of major limitations in the study. Some have to do with the problems of organizational research, and others have to do with the limited amount of time and resources available to the researcher. An initial problem, and one that is common to all studies of populations of organizations, is that the researcher had to begin the study by first, grouping a number of different organizations into a single set, e.g. mental health outpatient partnership clinics in Massachusetts, and second, treating them as similar entities.

Because the level of analysis of the study is organizational populations, it was necessary that the researcher assume that all the organizations within the organizational population were sufficiently similar to make it reasonable to compare their responses to environmental stimuli and draw inferences from this comparison. In treating all mental health outpatient partnership clinics in Massachusetts as an organizational population, the

researcher rationalized that their similar goals, philosophies, technologies, staffing, funding and histories, made it possible to group them. However, just as the boundary of an organization can be viewed as an arbitrary and changing concept, so can a population of organizations be viewed as an arbitrary grouping that a researcher creates according to her or his own criteria.

In this study, the researcher compared different organizational responses to the same environmental stimulus, hypothesizing that the organizations are more alike than they are different, and therefore, differences in response can be traced to the independent variable. If this assumption is not the case, and the organizations are significantly different in ways not controlled for in the study, then the results are not valid.

The second major problem in this study is that the researcher is attempting to test a model with universal implications in only one very limited context, i.e. outpatient mental health partnership clinics in Massachusetts. While there is some justification in the literature review for wider application of the model, most of the theoretical literature on the relationship between environment and organizations is relatively recent (within the past fifteen years), and there has been very little empirical testing of these theories. While this points to a

significant gap in the literature, and a need for further research, it also means that the model of leadership dependency has a slender theoretical and empirical base.

The third problem is an outgrowth of the second, in that the paucity of empirical research that examined the relationship between the environment, leadership, and organizations, made it difficult to justify the operationalization of the variables based on prior studies in the literature. While the Meyers (1978) study provided some precedent for the identification of a civil service leader as an independent leadership position, the Pfeffer & Salancik (1980) study of administrative succession made independent leadership operational based on the amount of ownership the leader had in the company he or she managed.

In order to counter this problem the researcher had to conduct a series of preliminary research interviews with key individuals in the field of mental health in Massachusetts. During those interviews, key figures in the field were asked to identify significant elements in the environment of mental health clinics and appropriate organizational responses to that environment. The information gathered from those interviews, augmented by the experience of the researcher in mental health administration from 1975 through 1980, provided the basis for the operational definition of the environment and the organizational strategic response of

clinics to the environment. The interviews are described in detail in Appendix 1 of this proposal.

A fourth problem or limitation in the study originates in the methodology and the researcher's limited resources. Initially, the study was to include all 47 partnership outpatient clinics in Massachusetts, and the researcher intended to collect information from various sources of aggregate data. After spending the better part of two months contacting and interviewing personnel in likely aggregate data sites, e.g., the Department of Mental Health central office, the Department of Public Welfare Medicaid Reimbursement for Mental Health Services Office, the Massachusetts Association of Mental Health, the researcher concluded that it was necessary to go to each individual clinic and collect data on site.

The need to go to each individual clinic in order to retrieve the data necessary for this study introduced a number of major constraints. An initial constraint was that the researcher could no longer include data from all forty-seven clinics since a number of clinics were unwilling to participate in the study, and the sheer magnitude of this effort was beyond the scope of a dissertation. A second constraint arose from the informal nature of the record keeping in the clinics. It soon became clear to the researcher that since most of the necessary data resided

only in the heads of the clinic employees, it was impractical to include clinics that had experienced a great deal of turnover in the leadership position, since most of the necessary historical data had departed with the departing director.

The fact that the clinics included in this study are those that (a) were willing to participate, and (b) had relatively stable leadership during the period of time under study created problems in the significance of the results. Consequently, any results from this study must necessarily be viewed as tentative and an indication of the need for further research.

Another problem is one that is endemic to all behavioral research. The researcher cannot randomly assign leaders to independent/dependent leadership categories. It may well be that the type of individual who self-selects her or himself into a civil service (independent) leadership position is inherently different from the person who elects to work for a board of directors (dependent position). If this is the case, than the dependent/independent dichotomous variable is little more than a proxy for an as yet undefined psycho-social characteristic.

A final problem in this study is inherent in the assumption upon which the study is based, and that is that leadership is effective. This study assumes that environmental dependency factors affecting the leadership position will result in the leader taking certain steps that will alter the organization's response to the environment. It assumes that the leader is <u>able</u> to take steps that will alter organizational response. If the leader is not able to take those steps, than the model will fail, whether or not environmental dependency is a key factor in leadership decision-making.

The researcher attempted to take this problem into account by selecting those centers that have had relatively stable leadership during the period from 1975 - 1980. The assumption here is that leadership stability is an indicator of leadership effectiveness. Clearly, there are some limitations in this assumption, and therefore, the question of leadership effectiveness remains a weakness in the study.

In summary, the limitations of this study have their origins in the relatively recent emergence of the concept of organization-environment interaction, the resource restrictions of the researcher, and finally, the methodological problems inherent in field research itself.

CHAPTER II

LITERATURE REVIEW AND ITS ROLE IN THE DEVELOPMENT OF THE LEADERSHIP DEPENDENCY MODEL

The first part of this chapter will consist of a general overview of the literature in the field of leadership and organization and environment model. The review of these studies helps clarify the definition given by this author to key variables of the leadership dependency model.

The last part of this chapter will focus on several "landmark" studies and theoretical papers that were central to the development of the leadership dependency model. These "landmark" studies include: Marshall Meyer's study of civil service leadership in 250 public finance agencies (Meyer, 1978); Pfeffer & Salancik's work in the area of resource dependency model of organizations and their environments (Pfeffer & Salancik, 1978) and their research on administrative succession in corporations (Pfeffer & Salancik, 1980); and Terreberry's theoretical essay on organizations and their environments (Terreberry, 1968).

Leadership and The External Organizational Environment

This section explores the special role that leadership can play when it assumes a boundary spanning function. Since this study defines leadership position dependency as the primary mediating variable determining the organization's selection of a response to environmental changes, it is important to review the literature background for the role of leader as boundary spanning link between the organization and the environment.

A presentation of the leadership dependency model must begin by pointing out the difference between characteristics of a leader and leadership position characteristics. Leader characteristics refer to the leader's personality and temperament, and the impact of those traits on leadership behavior. Blake & Mouton (1964) and Hershey & Blanchard (1977) assess the proportion of relationship versus task concern found in the leader's behavior, evaluating the success of the leader based on whether or not the leader's style matches the employees' leadership needs.

This study, however, looks at leadership position, which is defined as the leadership situation. It is independent of the personality traits of the person who occupies the leadership position and closely resembles

Weber's concept of "office" as opposed to office holder. This study also reflects the role conflict and role ambiguity research conducted by Lieberman (1955), Haney and Zimbardo (1973), and Hunt (1965) which examine the impact of a person's role on her behavior. While their research concludes that role does have a powerful impact on behavior, they stop short of examining the mechanism by which role impacts on behavior. In addition, their research does not directly address the relationship of role to organizational outcomes. By contrast this study will examine two particular aspects of the leadership role - dependency and accountability - in order to determine whether or not they influence, not only leadership behavior, but organizational behavior.

Leadership position dependence is defined as (1) the degree to which the leadership position is accountable to individuals and groups in the organization's environment, (as indicated by the job description of the top leadership position); and (2) the degree to which resources necessary to maintain the leadership position are provided by potent interest groups in the organization's environment.

Meyer (1978) was one of the few researchers to suggest that it was necessary to "focus on the larger network of variables in which leadership roles are imbedded" (1978, p.205), rather than on the social-psychological

characteristics of leaders. It was in this same article that Meyer introduced the concept of autonomous versus dependent leadership, examining this variable with respect to the leader's ability to protect the organization from uncertainties arising in the environment.

Meyer's (1978) article was central to the development of the leadership dependency model because he was the first researcher to define leadership dependency in a way that could be tested empirically. His study hypothesized that autonomous leadership (defined as civil service appointed) was able to shield the organization from environmentally initiated change, while dependent leadership (defined as politically appointed), was more likely to bring change from the environment into the organization.

Because this change is based on the premise that change originates in the environment, is mediated by the autonomous or dependent characteristics of the top leadership position, and is then passed into the organization, it is necessary to define environment and examine its impact on the organization. The next section contains a review of the literature on environment and organizations, and explains the origin of the concept of environment as it is used in the leadership dependency model.

The Impact of The Environment on The Organization

The organizational environment is defined here as (1) other formal organizations with which the focal organization interacts (Terreberry, 1968); and (2) the resources for which the focal organization competes in order to survive (Pfeffer & Salancik, 1978). The environment, then, is an objective reality of the focal organization. Needed resources and other organizations with which the focal organization interacts (formally and/or informally through resource, information, client exchange, etc.) do really exist in the objective world. However, the impact of this environment on the focal organization is mediated by the organization members' perceptions of the environment (Dill, 1962).

A good example of the effect of member selective perceptions on an organization is Chrysler Corporation, and the American auto industry in general, where management misperception of customer needs and environmental changes nearly destroyed the industry's ability to access necessary resources.

There are two different literatures that address the problem of how the environment impacts on the organization. Since the central hypothesis of his study attempts to explain the process by which the environment impacts on the

organization, both literatures will be reviewed.

Boundary Spanning and Resource Dependency

Several studies focus specifically on the role of the leader in an organization as "boundary spanner", theorizing that a primary role of leadership is to contend with environmental contingencies and uncertainties (Pfeffer & Salancik, 1978). Meyer (1978) in a study of 250 public finance agencies, tested leadership as a mediating variable between the environment and the organization.

The Meyer study, coupled with Pfeffer & Salancik's model of the relationship between leadership and the environment (1978), form the basis of the leadership dependence model. Meyer's work introduced the concept of the characteristics of the leadership position as opposed to the characteristics of the leader, as well as the concept of leadership position autonomy versus dependency. Pfeffer & Salancik's leadership model described the role of the leader with respect to the need for organizational acquisition of external resources, and the impact of external resource dependency on organizational perception of the environment.

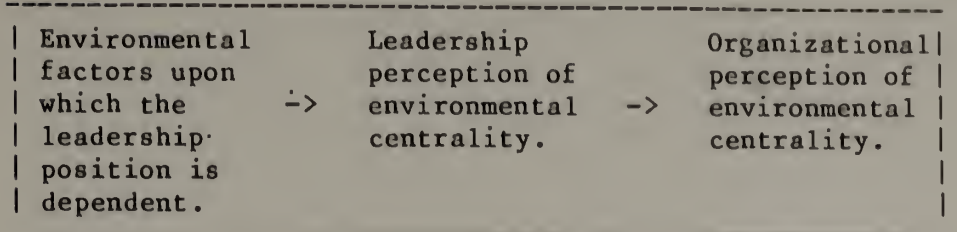
A primary role for top leadership, then, is to analyze the environment in order to determine the importance of its various influences to the workings of the organization

(Pfeffer & Salancik, 1978; Aldrich, 1979). Note that in this model the initiative for change originates in the environment, is mediated by the leadership position, and then affects the organization (see Figure 2).

If a primary role of top leadership is interpretation and analysis of the environment, it follows that individuals pay a proportionately greater amount of attention to those aspects of their environment upon which they are dependent (Blau, 1964; Pfeffer & Salancik, 1978). Therefore, a leader whose position is dependent to a great extent on environmental factors will be more likely to perceive the environment as occupying a position of central importance for the organization than the leader who does not have such strong dependency ties. Consequently, the leader in a strong dependency position will be more likely to pass along to the entire organization a belief that the organization's external environment is central to the organizational decision-making process. The relationship is illustrated by the following figure.

FIGURE 2

LEADERSHIP DEPENDENCY AND ORGANIZATION
PERCEPTION OF THE ENVIRONMENT



Because it is difficult to directly measure perception of the environment, this study hypothesizes that organizational perception of the environment will determine organizational selection of a response strategy to externally initiated change, termed Organizational Strategic Response or OSR. OSR can then be measured more easily than organizational perception. The next section presents the origins in the literature of the concept of organizational strategic response.

Organizational Strategic Response: The Dependent Variable.

The process of selecting a particular adaptation strategy in response to an environmental change is termed organizational strategic response. The choice of strategic response by the organization is the dependent variable in this study. The studies which have been done in this area

(Meyer, 1978; Salancik & Pfeffer, 1980), coupled with the author's personal experience as an executive director of a mental health outpatient clinic, suggest that leadership dependence is a critical variable in explaining how organizations respond to changes in their external environment.

In reviewing the literature that examines the relationship between environmental and organizational change, it became apparent that most organizational theorists begin by identifying different environmental dimensions or characteristics, such as the homo-heterogeneity of the environment (Thomson, 1967); the amount of organizational turbulence (Terreberry, 1968); or the dispersion of necessary resources (Aldrich, 1979). It is then theorized that depending upon the type of environment, certain kinds of organizational characteristics are more conducive to organizational survival than others. An example of this would be the principle stating that an older organization may have more trouble adapting to an unstable environment than a younger organization because it has more fixed routines (Aldrich, 1979).

The concept of organizational isomorphism, which refers to the phenomenon of an organization's character evolving to look like that of its environment (Emery & Trist, 1965; Dimaggio & Powell, 1981) further illustrates

the close relationship between an organization and its environment.

A problem that existed in the environmental theories up to this point is that the process through which the environment impacts on the organization is never addressed. While the theories describe environmental and organizational changes, they describe them as if they were parallel processes, and only imply that there may be a cause and effect relationship between environmental and organizational change. The question of <u>how</u> the environment enters the organization is still not addressed.

Weick (1976) has noted that organizations are only loosely coupled to their environment. This observation is supported by studies that reveal little direct correlation between the organization and its environment (Childs, 1972). Further evidence supporting only a loose environment-organization linkage is found in the fact that organizations are remarkably stable, resisting change even when the environment is in a state of upheaval (Pfeffer & Salancik, 1978).

The implication of these data is that there are one or more variables that moderate the links between the organization and its environment. Boundary spanners and boundary spanning units link the organization to its

environment in such a way that the technical core of the organization is able to function either despite, or in a coordinated fashion with, the environment (Thompson, 1967). While the boundary spanning literature explores the various kinds of boundary roles (March & Simon, 1958; Thompson, 1967; Hodge & Anthony, 1979), and hypothesizes that a relationship exists among organizational adaptability, environmental contingencies, and boundary roles (Aldrich, 1977; Hage & Aiken, 1970), there are few empirical studies that actually test the relationship between boundary roles and organizational change.

One study theorized that active boundary spanning increases the rate of organizational change because it funnels increased amounts of information into the organization (Hage & Aiken, 1967). In a study of sixteen welfare agencies, these researchers found that a higher degree of staff professionalism (which they equated with a higher degree of boundary spanning activity on the part of the staff), resulted in a higher rate of organizational change. Because this study tested the relationship between the network of staff relationships and organizational change, and determined that there was a significant relationship between the two variables, it implies that the rate of organizational change can be altered by the amount and type of external accountability requirements attached to

the boundary spanning role.

While the boundary spanning literature suggests a process whereby change is transmitted into the organization, it does not tend to focus on the role of top leadership in shaping organizational response to change.

The Evolution of Organizational Environments

Susan Terreberry's work was a benchmark essay in defining the relationship between the organization and its environment, particularly the modern "turbulent" environment and its affect on organizational structure. Terreberry's vivid description of a turbulent environment and its impact on organizations provided the initial theoretical construct that was used in developing the leadership dependency model.

Terreberry's article, while strictly theoretical, was seminal to this study because it examined and developed the thesis that Post World War II organizational environments had resulted in an increase in the ratio of externally induced to internally induced organizational change. The specific focus of her article was on the effect of the turbulent environment, which she defines as "one characterized by complexity as well as rapidity of change in causal interconnections in the environment" (Terreberry, 1968, p. 592), on organizational change.

The concept of an increasing amount of externally induced change, coupled with the argument that the organizational environment was becoming increasingly turbulent for all organizations, echoed my own experience as an executive director of a mental health agency and led me to examine the role of leadership in a system in which change originating in a complex external environment had more impact on the organization than traditional intra-organizational dynamics.

The theoretical literature of organizational change argued strongly that modern organizations were facing an increasingly complex and rapidly changing environment, the result of accelerating social and technological change (Ohlin, 1968, p. 63.). In place of traditional long range planning with its rational mathematical models, contingency based strategic planning had emerged, emphasizing responsiveness and organizational adaptability (Drucker, 1964; Gardner, 1963).

In applying this argument to my own experience in the field of mental health administration during the period from 1975 - 1980, I found numerous examples to support the conclusion that the environment was becoming increasingly more turbulent and unpredictable for outpatient mental health clinics.

Changes in mental health technology were challenging the traditional long-term psychoanalytic orientation of most of the psychologists and psychiatrists working in the field. Medical advances were producing new psychotropic medications that were allowing increasing numbers of emotionally disturbed individuals to control their behavior through medication and thereby live in the community rather than in institutions. A taxpayers' rebellion was forcing the Massachusetts State Hospitals, traditional refuges for the severely emotionally disturbed, to reduce staff and send patients out into the community. Increasing government regulation, coupled with the intervention of the legal system as a new participant in determining treatment for patients, all served to introduce additional complexities into the environment of the clinics that were included in this study.

Yet, despite the strong evidence that the environment these clinics operated in was a classically "turbulent" environment according to Terreberrry's definition, I found little evidence in many of the clinics that the organizations themselves recognized this fact and were adapting to the changes this new environment seemed to necessitate.

> In the short run, the openness of a living system to its environment enables it to take in ingredients from the environment for conversion into energy or information that allows it to maintain a steady state and, hence, to violate the dismal second law of thermodynamics (i.e. of entropy) (Terreberry, 68, 595).

In evolutionary model, organisms that fail to adapt to environmental changes eventually become extinct. Survival depends on the ability of the organism to change in response to changes in its external environment.

Terreberry argues that organizations survive only if they are able to adapt appropriately to environmental changes. Since the environment that she describes is a turbulent one, she argues that the appropriate survival strategy in response to this environment is one in which the focal organization develops transactional relationships with other organizations in its environment (Terreberry, 1968, p. 598).

The purpose of developing these relationships with other organizations in its environment is to regain some modicum measure of control over an environment in which complex interactions between a multitude of factors and organizations produces imperatives to change that are obscure in their origin and unpredictable in their timing. A focal organization that can extend its external sensors by linking with external organizations that are part of this

turbulent environment, is able to reduce some of the uncertainty by establishing through these formal linkages channels of communication that allow the focal organization to better anticipate environmental initiatives that require organizational adaption. (Aldrich, 1981; Terreberry, 1968; Blau, 1964; Aldrich, 1982; Pfeffer & Salancik, 1982).

In applying this concept to the situation of mental health centers in Massachusetts from 1975 - 1980, it is hypothesized on the basis of the literature, that clinics that were able to develop relationships with significant other organizations in their external environment would have found it easier to anticipate environmental change and would have been in a better position to adapt to those changes and survive.

For public outpatient clinics, significant other organizations operating in the environment included the Department of Mental Health (both central and local manifestations), significant elements in the local community, other social service agencies, local hospitals, private insurance agencies, and federal and state sources of third party reimbursement.

However, if linking with other organizations in the environment brought with it the benefit of increasing a focal organization's chance for survival, it also brought

with it a significant cost, and that was a loss of autonomy for the focal organization. (Terreberry, 1968; Aldrich, 1978; Pfeffer and Salancik, 1978; Blau, 1964).

In weighing the advantages of organizational autonomy versus the number of extra-organizational links necessary to secure survival in a turbulent environment, a number of subjective factors come into play that are difficult to measure in any traditional manner. The concept of autonomy itself is not one that lends itself to easy measures, yet the need to control its own destiny is a major, if unstated goal with every organization.

Linkages with external organizations can sometimes carry with them very explicit obligations, as in the case of legally binding contracts that spell out the restrictions that a focal organization must accept in order to maintain the relationship. On the other hand, the linkages can be very vague, supported only by the expectation of good will negotiated between the leadership of the organizations involved in the transaction. However, in either case, the restrictions on organizational autonomy entailed by the linkages are a very real cost that the organization must pay in order to survive in a turbulent environment.

Terreberry's article was an intriguing analysis of the role of environment in organizational change, and it dramatically illustrated the need for developing inter-organizational relationships in order to survive in a complex and turbulent environment. In addition, the definition of a turbulent environment contained in the article reflected the state of the environment that confronted mental health centers during the period from 1975 - 1980. However, Terreberry was not at all concerned with the manner in which an organization came to perceive its external environment, nor the reason why some organizations seemed to choose extinction rather than sacrifice autonomy, while others were quick to form the critical external linkages necessary to survive.

In looking at clinics in Massachusetts I noted that many had chosen an organizational path that seemed to insure eventual organizational extinction rather than sacrifice autonomous self-determination, while others were easily able to adapt to change initiatives originating in the environment and were willing to sacrifice a great deal of organizational autonomy in order to establish critical external linkages.

I hypothesized that the top leadership of the organization was a critical element in the final organizational decision to choose between autonomy versus

adaptability. In order to pursue the question of how top leadership affected the choices an organization might make in response to a turbulent environment, it was necessary to move on to a pair of organizational theorists who incorporated much of Terreberry's work on organizations and turbulent environments, but who also added the component of leadership and organizational choice to their theoretical model.

A Resource Dependence Perspective

Pfeffer and Salancik's book is essentially an argument that organization's are controlled by their external environments. Within this context, the goal of the organization is to survive through the acquisition and retention of resources, and the role of management is to insure organizational survival by overseeing this process of resource acquisition and retention (Pfeffer and Salancik, 1968, p. 2).

Because organizations are not self-contained, they must develop strategies that allow them to transact with elements in the external environment in order to acquire necessary resources. The more turbulent (complex and changing) the environment, the less stable the sources of critical resources, and the more time and energy the

organization must devote to acquiring those resources (Pfeffer & Salancik, 1968, p. 46).

The authors contend that most of the organizational behavior literature focuses on issues surrounding the efficient use of resources once they are inside an organization, paying no attention to the organizational behavior implications of the problem of acquiring those resources (Pfeffer & Salancik, 1968, p. 3).

The authors' focus on issues of organizational survival and resource acquisition provided me with a context within which to analyze my own experience as an Executive Director of an outpatient mental health center, as well as a perspective within which to conduct my dissertation study.

When I initially assumed the role of Executive Director of an outpatient clinic, I was both familiar with and a firm believer in the work of organizational behaviorists such as Blake and Mouton (1964), Hershey and Blanchard (1977), and Fiedler (1967).Their leadership theories and research grew out of the behaviorist school of motivational model characterized by writers and researchers such as Mayo (1933), who was one of the two Harvard researchers who conducted the now famous Hawthorne experiment. This experiment demonstrated that workers were motivated by psychological factors that could overcome

traditional hygiene factors such as physical comfort and money (Hawthorne experiment conducted by Elton Mayo and Fritz Roethlisberger from 1927 - 1932).

Their work was followed by contributors such as Douglas McGregor, whose Theory X and Theory Y set of assumptions about human motivation are still a basic principle in assessment of management style. Maslow's hierarchy of human needs provided researchers' with a typology that could be used to evaluate the most effective motivational strategy that a worker would be likely to respond to in a given situation. (Maslow, 1943).

In 1959 Herzberg introduced his "Two factor model of Motivation" that asserted that worker motivation was affected by two different sets of motivators: Job context motivators which consisted of working conditions, pay, and relationship to supervisor; and job content factors which had to do with the recognition, learning opportunities, and sense of accomplishment associated with the job itself. He felt that traditional management relied almost exclusively on job context factors to motivate employees, thereby overlooking the importance of job content factors in employee motivation.

These various theories of human motivation inevitably gave rise to theories of management behavior that would incorporate the new knowledge gained from the behavioral scientists. The earliest leadership studies identified two major dimensions to leadership behavior; task achievement orientation and employee satisfaction orientation (Fleishman, 1953; Likert, 1961). These two dimensions were separate and a manager could be high in one dimension and low in another. The most effective leader was the one who scored high on both dimensions.

Later a third dimension was added to the task versus employee satisfaction dimension - that of personality (Zaleznik, 1977). This model proposed that there were some people who were naturally people oriented (and thus high on the employee satisfaction dimension of leadership), while others were task oriented managers who had a personality-based tendency to subordinate employees needs to achieving goals.

A fourth dimension introduced into the concept of management behavior was that of the "favorableness of the situation" (Fiedler, 1967). In this case favorableness of the situation tended to refer to elements of the situation within the organization such as: the quality of the leader-member relationship, the ambiguity versus explicitness of the task structure, and the position power of the leader

that allows her or him access to critical reward and punishment resources (this last element indirectly indicates the importance of resource acquisition but does not address the importance of the source of those resources).

Hershey and Blanchard (1977) introduced an additional contingency into the factors that determine management behavior, the "task relevant maturity level" of the group that is being managed. Task relevant maturity level includes such factors as: competence, achievement motivation, willingness to assume responsibility, self-respect, self-confidence, and self-esteem. Management behavior is dependent upon the degree of task relevant maturity exhibited by the group that is being managed.

Another perspective on management behavior analyzes behavior based upon the type of decisions a leader must make and the elements that influence the implementation of that decision (Vroom and Yetton, 1973). Based upon an analysis of the type of decision and its implementation, a leader can then choose from essentially three strategies: (1) autocratic, (2) consultative, and (3) group process.(Vroom and Yetton, 1973).

While all of these theorists and researchers contributed a significant amount of insight to the process of analyzing and understanding leadership behavior, they

paid no attention to the role that the external organizational environment could play in influencing this behavior.

Yet my own experience as a manager in an outpatient mental health clinic indicated that the omission of external environmental factors from the analysis of leadership behavior was a serious one. I theorized that frequently when organizational behavioralists observed leadership behavior, they attributed it to personality based factors because there appeared to be no rational explanation based upon dynamics within the organization. As a result, they were failing to incorporate the leader's perception of the external environment as a factor in determining that leader's behavior.

Thus, when Pfeffer and Salancik asserted that (a) the primary goal of an organization is survival and (b) the key to survival is both the acquisition and the efficient maintenance of resources, it became apparent to me that ensuring the organization's survival is the major task of management, and that this entailed acquiring as well as managing resources.

The question of how the resource acquisition requirement altered leadership behavior, and how changes in the scarcity, concentration, or predictability of critical

resources altered management perception of the environment, emerged as the focus of my study.

However, Pfeffer and Salancik (1978) were far more interested in the impact of the external environment on the organization as a whole than on the specific role leadership could play in mediating the relationship between the external environment and organizational change.

They argue that the environmental context will result in the selection of an administrator who is appropriate for that context. Thus, for example, an organization confronted with a complex and critical legal environment will begin to reflect this fact by the proliferation of lawyers in the top management structure. (Pfeffer & Salancik, 1978, p. 242).

Their model does define three distinct roles for top management: (1) symbol; (2) advocator; and (3) processor (Pfeffer & Salancik, 1978). The symbolic role has its origin in the fact that individuals want to believe that they have control over their environment (Blau, 1964; Lieberson & O'Connor, 1972). By attributing organizational success or failure to a manager, we can reduce complex and obscure causes to the actions of a single individual, and thereby maintain an illusion of control (Gamson & Scotch, 1964).

The advocator manager is one who is "an active manipulator of constraints and the social setting in which the organization is imbedded" (Pfeffer & Salancik, 1978, p. 19). The processor manager is one who identifies the constraints in the organization's environment and then makes adjustments within the organization (Pfeffer & Salancik, 1978, p. 20).

In reality, of course, an effective administrator is one who acknowledges and integrates all of these roles in order to maximize the acquisition of critical resources.

It is clear that by this point both my reading and my leadership experiences had taken me a long way from the traditional management literature in which leadership effectiveness was defined solely in respect to the impact of the behavior on motivating employees. While employee motivation remains a critical and necessary component of effective leadership, it is not the only component. The need for the leader to acquire critical resources from the external environment is a primary determinant of leadership behavior and effectiveness.

However, the organizational environment confronting mental health centers in Massachusetts during the period of this study was turbulent, which meant that causal relationships within the external environment were obscure

and difficult to determine. As a result, perceptions of the environment and its impact on the mental health centers, could differ widely from one mental health center to another.

As I proceeded through the literature, my research question began to focus increasingly upon those factors that determined how an administrator perceived the external environment. For example, some mental health center administrators failed to perceive the deinstitutionalization of mental health in Massachusetts as an environmental change that was relevant to their centers, while others defined it as the most critical change occurring in mental health in the State. What accounted for this difference in perception?

At this point I began to search for empirical studies that attempted to test the relationship between leadership characteristics and perceptions of the external environment.

Pfeffer and Salancik (1978) conducted a study of hospital administrators that produced a slight but significant correlation between formal training of the administrators and the type of external funding that the hospital depended upon. In those cases in which the administrator had greater formal training, the hospital derived a greater amount of its funding from insurance

sources. In those cases in which the administrator had less formal training, funding tended to come less from insurance sources and more from private sources (Pfeffer and Salancik, 1978, p. 243).

An interesting component of this study was the fact that when the factor of administrative tenure, i.e. the length of time the administrator was in the position, was considered, much stronger correlations emerged. For administrators who had been in their positions less than four years, there was a much stronger correlation between formal training and amount of insurance funding for the hospital (Pfeffer and Salancik, 1978, p. 243).

The researchers concluded from this fact that longer tenure results in "stable, institutionalized structures of control" that can serve to insulate the organization from environmental contingencies (Pfeffer and Salancik, 1978, p. 243).

As a rule, there is a positive relationship between organizational performance and executive tenure, such that the length of executive tenure increases when the organization is doing well and declines when the organization is doing poorly (McEachern, 1975; Pfeffer & Leblebici, 1973; Grusky, 1961, 1963; Salancik, Staw and Pondy, 1978). Pfeffer and Salancik

theorize that institutionalized power can have an impact on this relationship (Pfeffer & Salancik, 1978). In a study of hospital administrators, they determined that the characteristics of newly appointed administrators more closely matched the contingencies facing the organization, than did the characteristics of firmly entrenched, longer tenured administrators (Pfeffer & Salancik, 1977).

Because leadership behavior was not usually a primary concern for Pfeffer and Salancik, their empirical studies did not probe the specific components of the leadership position that produced the "stable, institutionalized structures of control". However, an exception to this general lack of interest in the specific role that leadership played in organization change, was a 1980 study of the relationship between executive tenure and ownership and performance of eighty-four United States Corporations (Salancik & Pfeffer, 1980).

In their study of the effects of ownership on eighty-four U.S. Corporations, Salancik & Pfeffer (1980) borrow a concept from McEachern (1975) and divide corporate ownership into three categories: (1) owner managed in which stock is concentrated in the hands of the managers; (2) management controlled in which stock is dispersed among many shareholders; and (3) externally controlled in which stock is concentrated in the hands of a few individuals who do not

manage the firm.

Data from the study indicated that there was a direct relationship between ownership and chief executive tenure, and that ownership appeared to mediate the relationship between chief executive tenure and firm performance (Salancik & Pfeffer, 1980).

The researchers argue that this relationship evolves from a model of resource dependency which states that individual or organizational power is the result of the ability to access or provide to others critical resources. The availability of alternative sources of critical resources reduces the dependence of the focal organization or individual or any single resource, thereby reducing the power of that resource over the focal person or organization (Emerson, 1962; Blau, 1964; Pfeffer & Salancik, 1978).

Thus, in the case of the owner managed firm, concentrated power (stock ownership) is aligned with the firm's management, creating a situation in which executive tenure is less dependent on variations in the firm's performance (at least in the short run). However, when stock is concentrated in the hands of a few key shareholders who are <u>not</u> managers of the firm, the study indicated that concentrated power that is not aligned with management can quickly become concentrated opposition, and result in

shorter executive tenure periods that were critically dependent upon fluctuations in the firms performance (McEachern, 1975; Salancik & Pfeffer, 1980). Finally, in the case of the stockholder owned firms, in which stocks were widely dispersed among numerous shareholders, power was not easily concentrated, and executive tenure was not directly impacted by firm performance except in those cases in which a hostile takeover bid resulted in stock concentration, or angry stockholders initiated a proxy fight (Salancik & Pfeffer, 1980).

There are many parallels between the study by Salancik and Pfeffer (1980) and my dissertation research. Their independent variable was the resource dependency level of the top executive position, defined in terms of the type of stock ownership. Translating that variable to the public sector where there is no stock ownership, I made the independent variable the resource dependency level of the top executive, defined by (1) the accountability demands and (2) the salary source of the top leadership position.

However, in Pfeffer and Salancik's study (1980), firm performance is a moderating variable between the independent variable (type of stock ownership), and the dependent variable (executive tenure). In the absence of a profit motive in the public sector, there is less likely to be general agreement about just what is good versus bad firm

performance, and executive tenure is frequently impacted by complex political issues, resulting in a high turnover rate that can be attributed to a multitude of different causes. (Between 1978 - 1982 there was a change in the top management position of every mental health facility in Franklin and Hampshire counties, involving a total of eight different agencies. And of the 48 partnership mental health institutions in Massachusetts, only 12 had no leadership change between 1975 and 1980.)

Consequently, I eliminated executive tenure as a meaningful concept from my dissertation research, and substituted organizational change as a dependent variable. In addition, I defined partnership mental health clinics as an organizational "set" with similar goals, technologies, histories, and staffing patterns, and thereby treated them as organizations with the same kinds of environmental pressures that would have produced the same kind of organizational changes, but for the influence of the top leadership position.

From the perspective of my dissertation research, there were two major differences between Salancik and Pfeffer's (1980) study and the study that I conducted of partnership mental health centers. First, there was the fact that Salancik and Pfeffer looked at for-profit corporations, thereby allowing them to define firm

performance strictly in terms of an increase or decrease in firm profits. Second, their focus on executive tenure was not a relevant variable in a study of mental health centers.

However, the resource dependency model as a basis for understanding the role of the top leadership position in respect to the external environment became a cornerstone of my dissertation research. In order to locate an empirical study that more closely reflected the unique characteristics of not for profit organizations, it was necessary to turn to the work of Marshall Meyer (1978).

The Impact of Leadership on the Relationship Between the Environment and Organizational Change

Meyer (1978) was interested in the effects of leadership on the administrative structures of organizations. The results of his study showed that the characteristics of the leadership position did indeed have a major impact upon the structure of the organization. The importance of this study to my research question was based on the fact that the leadership position characteristics that Meyer studied were the result of the leadership position's relationship to the external environment of the organization. Hence, in his study, Meyer examined the relationship between the external environment, the

leadership position characteristics, and changes inside the organization itself.

The organizations in his study were city, county, and state departments of finance lead by chief financial officers. Through the sixties and seventies these departments had been drastically affected by changes in the external environment. Two of the most significant changes were in the use of computer technology and the advent of various types of cost-benefit accounting.

Initially, finance departments controlled the new computer technology because they were the primary users. However, the relevance of computer data processing to other departments meant that there was a tendency to move the Management Information Systems out of the finance area. In addition, the new types of cost-benefit analysis that were becoming increasingly popular involved hypothesis generation, or guess-work that was "anathema" to the traditional accountant, so that after a while much of the budget planning responsibility was also moved out of the finance departments (Meyer, 1978, p. 202).

The general result of these changes was a contraction of the finance departments. However, Meyer's study showed that leadership position characteristics could have a significant effect on this contraction process (Meyer, 1978,

p. 205).

Because most empirical studies have not been able to demonstrate a significant relationship between leadership behavior and employee or overall organizational performance (Graen, Dansereau, and Minami, 1972; Lieberson and O'Connor, 1972), there is a tendency in the literature to minimize the importance of leadership to an organization. Meyer (1978) points out that this assumption goes against common sense as well as overlooking the potential relationship between leadership characteristics and other organizational variables not usually associated with performance.

His study demonstrates that there is a small but significant relationship between the stability of leadership and the stability of organizational structures. In addition, his study shows a correlation between leadership variables and causal relationships between organizational variables (Meyer, 1978. p. 227).

In those organizations where leadership was stable, autonomous and insular, there was little causal relationship between organizational variables. But in those organizations with a high turnover in the leadership position, and significant dependence on higher authority, the causal relationship between organizational variables was very high.

Based on the results of this study Meyer argues that the "function of leadership is to mediate between environmental uncertainties and organizational structure." (Meyer, 1978, p. 203.).

Meyer's study focuses on the "network of relationships" in which the leadership role is imbedded. (Meyer, 1978, p. 295). rather than on the psychological characteristics of the leader. He hypothesizes that to the extent that a leadership position is independent of higher authority, it is more capable of protecting the organization from uncertainties arising in the environment (Meyer, 1978, p. 208).

Thus, a leadership position that is vulnerable to external pressure is more likely to allow that external pressure to intrude upon the internal organizational structure. And, the more stable the leadership position is, the less likely it is to be vulnerable to external pressure, and therefore the better able the position is to protect the organization from changes originating in the external environment (Meyer, 1978, p. 223).

Meyer examined organizational change in 215 city, county, and state departments of finance over a period of six years. He looked at changes in organization size, the number of divisions, the number of levels of supervision and

the number of sections within each department. He discovered that there was a relationship between continuity in leadership from an earlier period and a lower level of organizational change at a latter period. This data led him to infer that the earlier period leadership stability resulted in the organizational stability at a later period. The attempt here was to determine whether the lack of change was the "result " of leadership stability, rather than the other way around. This hypothesis was supported by the fact that organizational change at an earlier period did not predict leadership change at a later period of time (Meyer, 1978, p. 118).

His second hypothesis was that autonomous leadership, i.e. leadership that was relatively independent of higher authority, was better able to shield an organization from changes originating in the external environment, than "dependent leadership". Meyer felt that the method of appointment was the key variable in determining the autonomy/dependence of an administrator. Thus, he defined an autonomous administrator as one who is either elected or appointed through civil service steps, and a dependent administrator as one who is appointed by an immediate superior or through a political appointment. (Meyer, 1978, p. 212).

He determined that there was less change in organizational variables when the administrator was "autonomous" or independent from higher authority. Where the chief administrators were politically appointed, and therefore more vulnerable to pressure from higher authority, there was a significantly greater amount of change in the organizations studied.

The essential elements of Meyer's research as it pertained to my area of interest can be found in the following hypotheses, all of which were supported by the findings of his study:

1. Leadership can allow or prevent external change from entering an organization.

2. Organizational change can be resisted by firmly entrenched, (i.e. independent) leadership.

3. The focus on leadership research should be on the characteristics of the leadership position rather than on the psychological characteristics of the people who occupy those positions.

4. The more autonomous the leadership position, the more likely is it that the organization would resist externally initiated change.

5. The more dependent the leadership position, the more likely that change will be introduced into the organization.

6. Autonomous versus dependent leadership were defined by the "method of appointment" of the leadership position.

Meyer is quick to point out that he only looked at leadership in one type of organization, and that the characteristics of the leadership position may not operate "as so effective a filter of uncertainty for organizations operating in more dynamic and turbulent environments"(Meyer, 1978, p. 229).

The application of Meyers research to this dissertation study is obvious in both the definition of the independent variable - independent versus dependent leadership - and in the identification of an organizational "set" of similar organizations with either dependent or independent leadership positions.

In addition, the attempt to measure organizational change by comparing changes in specific organizational variables after a several year long interval of time (in the case of this dissertation study, five years), was used in both of our studies.

Conceptually, there were several aspects of Meyer´s research that made it valuable to me in developing this dissertation study. The first was his portrayal of the leadership position as a mediating link between the external environment and the organization itself.

The second concept was the focus on the leadership position characteristics rather than on the psychological characteristics of the leader as a primary determinant in predicting the leadership response to externally initiated change.

While I made leadership dependency/independency operational in a somewhat different way than did Meyer - instead of method of appointment I defined it as a result of the accountability and source of salary for the top leadership position - the concept of independent versus dependent leadership is clearly drawn from his work.

Conclusion

The intent of this dissertation study is to clarify the role of leadership within the environmental perspective of organizational change. Convinced that the traditional leadership literature, with its almost exclusive focus upon the psychological characteristics of the leadership position, had failed to recognize the extraordinary influence of the external environment upon leadership behavior, I turned to the literature of organizations and environments. While this body of literature did acknowledge the importance of the external environment, it tended to ignore the role of the leadership position in organizational change.

This chapter focussed on several articles and research studies that were seminal to the development of the leadership dependency model tested in this study. Terreberry (1968) first clearly defined the modern "turbulent" environment and its dramatic effects on organizational change. This article first captured for me the essence of the external environment that confronted partnership mental health clinics during the period from 1975 - 1980.

Pfeffer & Salancik (1978) and Salancik & Pfeffer (1980) resource dependency model provided me with an understanding of how the external environment enters the organization, and the first clue as to why a leader could resist the encroachments of externally initiated change.

Finally, Meyer's (1978) study of public finance institutions introduced the idea of the autonomous versus dependent leadership position, further refining the resource dependency concept, and providing the basis for the leadership dependency model used in the study which follows.

C H A P T E R I I I

THE ENVIRONMENT OF PARTNERSHIP MENTAL HEALTH CLINICS IN MASSACHUSETTS FROM 1976 - 1980

The Preliminary Research that Resulted in the Identification of the Environmental Stimuli and the Organizational Strategic Responses (OSR)

In order to develop the leadership dependency model that is tested in this study, and then make operational the variables so that they could be tested, the researcher had to do a considerable amount of preliminary research.

This research consisted of interviews with a number of mental health professionals, researchers, and policy makers throughout the state in order to gain their perspective on the environment and organizational strategic responses of partnership mental health clinics in Massachusetts during the period from 1976 - 1980.

Another goal in conducting this preliminary research was to investigate the amount and the quality of the data that actually existed on mental heath centers. I discovered at an early stage in my preliminary research that the existing aggregate data bases contained inaccurate and

inconsistent data and amended my original research idea, which was to use aggregate data sources, to one in which I collected data from each clinic.

While these preliminary interviews were exploratory in nature, the central topic discussed at each interview was: What were the major changes that needed to have occurred in partnership mental health clinics from 1976 - 1980 in order for those clinics to have responded to the significant environmental changes that were occurring in the mental health field at that time? Interviewees consisted of clinic directors, Department of Mental Health central office staff, and DMH area office staff. The dependent variables were identified as a result of those discussions, augmented by my own experience as a clinic director (where I was exposed to state wide clinic concerns as a result of my membership in three different state-wide clinic associations).

In an early interview with a DMH central office consultant I asked about the possibility of using data bases within the department and he indicated that there was no reliable data that he knew of. He gave me the preliminary results of a telephone survey conducted by the Department on partnership clinics

in June of 1980. I was eager to look at the study because it measured billing revenues in clinics from 1976 - 1980, and average number of clients in each payment category. However, I was told that the Department had discarded the study as little more than ball park approximations and that it had no value as a measurement tool. I was given a copy of the study but was told not release any of the data on the study since the results were so clearly not valid.

Another set back to the idea of using aggregate data occurred when I discovered that all historical materials documenting the early years of partnership clinics had been discarded when the Department of Mental Health moved from Ashburton Place to its current location on Washington Street. However, Ms. Mary Remar, Chief of Volunteer Services for the Department of Mental Health did send me a copy of her masters thesis entitled "The Interaction between the Public and Private Sector on Human Services Policy", (1966). Her thesis contained an excellent section on the history of the partnership clinics and I used it as the basis for my discussion of the evolution of the clinic director's position in these clinics.

An interview that yielded a a great deal of information about the evolution of partnership clinics was conducted with an employee of the central DMH office who had

been in his position for more than twenty years. He discussed management inequities in partnership clinics that have developed over the years because of the ongoing confusion surrounding clinic accountability.

He discussed the resistance of clinic directors in the early seventies to the concept of third party billing, and their indignation at having to do the billing themselves. He felt that the medical staff leadership in the clinics further served to isolate them from their immediate communities since they fostered an elitist attitude on the part of clinic staff.

It was he that first suggested most of the change variables that were used to make operational the four organizational response variables used in this study.

Another DMH central office employee addressed the issue of clinic autonomy in a manner that supported the contention in this study that the DMH civil service employed director of a partnership clinic exercised a considerable amount of autonomy. The employee said that the Department of Mental Health had always been primarily concerned with its major institutions and that the partnership clinics consumed such a small percentage of Department funds that there had been little motivation for DMH to strictly supervise the clinics and their activities. She also stated

that the areaization policy pursued by Okin was supposed to address that problem but that the clinics had become used to years of autonomy and were very resistant to the new accountability standards imposed by locally based area directors.

This interviewee was the first person to suggest that civil service leaders tended to have a very different orientation toward accountability demands in the environment than do directors employed by local boards.

An interview conducted with a DMH Area Director was revealing in that he commented on the fact that there was little communication between area directors and each area was unique in the management structure that it adopted. As a result, he suggested that in many areas where the partnership clinic director had been in her or his position prior to the appointment of the area director, the newly appointed DMH area director found it difficult, if not impossible, to establish any kind of accountability relationship with the clinic director.

A meeting with an employee of the Massachusetts Department of Public Welfare (DPW) was conducted in order to investigate whether or not the Department of Public Welfare, which reviewed all medicaid reimbursements, had any aggregate data on changes in the amount of third party

billings for medicaid that occurred in each clinic from 1976 - 1980. While this employee was very helpful in letting me look at DPW files, she was unable to locate any aggregate data. A discussion with several staff people working on the development of a computerized management information system revealed that they also had no aggregate data on partnership clinic reimbursement.

This information, supported by similar reports from the Department of Mental Health itself, and the Rate Setting Commission, resulted in the decision to go to each individual clinic to collect accurate data.

However, reviewing DPW files was in itself a revealing and worthwhile experience. Much of the data used to make operational the variables in this study were drawn from documents provided to me by the DPW.

A significant environmental change for clinics was the result of a law passed at the 1977 regular session of the Massachusetts Legislature (Ch. 118, CMHC Operation, Section 1). This law stated that:

> "...the Department [of Mental Health], may... enter into agreements with non-profit charitable corporations... for the establishment and maintenance of community mental health centers...Such agreements may provide for the retention of all revenues resulting from all billings and third party reimbursements by the non-profit charitable corporations, partnerships, or collaboratives..."

Prior to this ruling the clinics had to return two-thirds of every dollar collected in third party billings to the Massachusetts' general fund. As a result there had been little incentive for clinics to pursue an aggressive billing policy since the administrative costs of an efficient billing system were almost equal to the money that the clinics were allowed to retain.

With the passage of what came to be known as the "100% ruling", even the most administratively conservative clinics realized an immediate tripling of medicaid reimbursement funds. Clinics that were willing to develop the administrative capacity necessary to aggressively pursue third party reimbursement, discovered a bonanza in new, unrestricted funds.

An interview conducted with the Director of a Community Mental Health Center who had been very active in state-wide mental health center organizations focused on a discussion of potential sources of aggregate data on partnership clinics and federal community mental heath centers in Massachusetts. The interviewee said that all aggregate data sources available contained nothing but "garbage" and that I should not use aggregate sources, but should go to the clinics themselves for reliable data.

A second interview with held in order to test the validity of the measures I wanted to use for my variables in the study. The interviewees state-wide perspective was particularly important to this discussion.

Asked what he thought were the most important changes in mental health in Massachusetts during the period from 1976 - 1980, he pointed out that Okin's stewardship as Massachusetts DMH commissioner was almost exactly contiguous with that period of time. He offered the following opinion of the major mental health changes during that period.

1. The development of community based services for chronic clients.

2. the advent of the Consent Decree - which, while it only affected DMH Region I directly, had immense indirect impact on mental heath policies throughout the State. (The Consent Decree was a legal agreement signed by the DMH and a group of Northampton State Hospital clients in which the DMH agreed to establish appropriate community based treatment alternatives to institutionalization to clients hospitalized at Northampton State).

3. The push to close down state Mental Health Hospitals.

4. The decision on the part of DMH to stop providing funds for outpatient services to the general population, and begin to direct those resources to providing outpatient services to the chronically mentally ill.

He commented that all this had immense impact on the mechanisms for service provision, which included issues such as:

1. Areaization - Authority and Responsibility for delivery of DMH services was delegated to 40 relatively small service areas run by area directors. Theoretically, this resulted in increased accountability for community based services.

2. Conversion - DMH intended to use conversion to switch to a contract for service system with vendors. It never worked because of DMH administrative ineptitude, Union opposition, and clinic opposition.

3. Revenue Retention - He noted that the Department of Mental Health and the Unions both allowed salary augmentation; i.e. if a civil service salary was considered too low, clinics could augment the salary from local or other sources. As long as this continued, there was little incentive to convert in order to provide employees with market competitive salaries.

He also pointed out that revenue retention raised difficult questions about clinic autonomy that were never resolved, i.e. did DMH have the authority (never mind the ability) to set priorities for clinics in the use of their medicaid funds. At this point he referred to the history of clinic autonomy and their tradition of resistance to DMH control.

In order to further understand the issues and problems that made up the environment of partnership clinics during the period from 1976 - 1980 an historical perspective is helpful. The following section summarizes the history of the Department of Mental Health in Massachusetts and provides some insight into the origins of the problems that existed during the period examined in this study. Because much of this information comes from DMH central office employees rather than documents (due to the loss of archival data described in the preceding section), and because I promised anonymity to these employees, there are few citations.

The Department of Mental Health: A Brief History

The departmental predecessor to the Massachusetts Department of Mental Health was the Division of Mental Hygiene, established in 1922. Responsible for all aspects

of the mental health of the citizens of the Commonwealth, the Division was also empowered to establish outpatient clinics. These first outpatient clinics were known as Child Guidance Clinics, and in 1958 became the partnership outpatient clinics that now number 48, distributed throughout the state (Remar, 1966).

The partnership clinics functioned under a peculiar shared management arrangement between the Division of Mental Hygiene and the local community, whereby the state placed professional clinical employees, including a psychiatrist-director, in the agency, and a local citizens' board raised money and managed the physical plant and secretarial support services needed. The civil service employees placed in the clinic were not accountable to the local citizen board, but to a centralized state bureaucracy that was geographically distant and preoccupied with the enormous task of managing the state's twelve overcrowded mental hospitals, plus eight state institutions for the mentally retarded.

As a result of this situation the clinic leader in each center functioned with almost complete autonomy, independent of the local citizen board by virtue of civil service status, and independent of civil service management by virtue of geographical distance and the state's inability to manage this relatively small area of responsibility.

The clinic director's leadership autonomy is further enhanced by the strong tradition in mental health of professional rather than organizational loyalty, which results in a strong feeling that the mental health professional is primarily accountable to her or his professional peers. This belief in the professional autonomy of the profession is both paralleled and reinforced by the traditional sanctity of the therapist/client relationship (Feldman, 1978).

On the other hand, the leadership position characteristics of an executive director, hired by a local board of directors was vastly different. Part of the reason for the difference can be found in the factors that prompted local boards to hire an executive director, rather than rely on the civil service employed clinic director to run the organization. First, the local boards themselves were frustrated by the lack of control they could exercise over the clinic. Executive directors were hired partially as a result of the local boards' perception that the civil service employed directors were not concerned with local community needs, and were unresponsive to the concerns of the local board of directors. Second, most civil service appointed directors were primarily clinicians, with little interest in or experience with non-profit management. Citizen boards, held fiscally accountable for their clinics,

felt a strong need to bring in leaders with the administrative and management sophistication necessary to insure fiscal solvency.

As a result, executive directors hired by local citizen boards were much more likely to feel intense pressure to (1) insure that the clinic would remain fiscally solvent, and (2) respond to community perceptions of mental health problems and the appropriate role of the clinic in the community. The methodology of this study is based on the hypothesis that this type of pressure resulted in an increased tendency for the executive director to scan the environment in order to locate necessary funds, and a tendency to alter program structure and clinical philosophy in order to make the agency more responsive to local community concerns.

The next section draws on information gained during the pre-study interviews and an awareness of the unique history of the DMH and partnership clinics to identify the major environmental stimuli that were operating in the mental health environment during the period from 1976 - 1980.

The Environmental Stimuli

(1) Communitization of chronic and high risk clients. As DMH continued the process of closing down its large state mental hospitals, clients with increasingly severe and chronic emotional disturbances were being released into communities, creating a need for community based mental health services. The partnership mental health outpatient clinics were under enormous pressure to serve this population. Clinics that responded to this environmental change had to develop new programs, since the chronic and high risk population are not appropriate for the long-term, psychoanalytic therapy historically offered by the clinics.

(2) The DMH shift to contracted services and the corresponding increase in agency accountability. In 1975 the DMH made a policy decision to stop placing civil service employees in outpatient clinics and instead to develop service contracts with clinics. This meant, for example, that instead of a $20,000 psychologist civil service position, the agency was awarded a contract for $20,000 to perform specified psychological services. The agency would then hire its own employee(s) to do the job.

Because service contracts specified performance requirements, the questions of monitoring, accountability, and agency output needed to be addressed. Those clinics

that were able to respond to these increased accountability demands had to revamp their administrative structure and increase overhead in order to develop the management information capability necessary to do responsible contract management.

(3) Increase in third party reimbursement through 100% medicaid retention. In 1978, a new ruling was passed by the Massachusetts legislature that allowed partnership clinics to retain 100% of their medicaid reimbursement money. Prior to that time the clinics had to return two-thirds of every dollar collected to the Massachusetts common fund. At that time clinics billed medicaid $30 for every hour of direct service delivered to a client, so that this ruling could potentially provide each clinic with an important new source of revenue. In order to take optimal advantage of this new ruling however, clinics had to revamp their billing systems and increase their administrative capacity in order to process the necessary paper work.

The purpose of the preliminary research was to solicit information from mental health experts throughout the state that could be used in determining the environmental stimuli and the operationalization of OSR responses. The information obtained through the interviews was supplemented by a review of written documents including memos and minutes from key meetings. (Additional information gained during

the preliminary research period can be founded in Appendix 1.)

In order to make operational the variables tested in this study it was necessary to conduct preliminary research and use information gained in interviews with experts and leaders in the mental health field as well as from written documents. In reading both the methods and the results section of this study it is important to remember that this research not only tests a model, but tests the validity of the way in which the model was made operational.

C H A P T E R I V

METHOD

Introduction

In order to test the leadership dependency model, it was necessary to measure organizational response in organizations that had leaders who occupied positions with high accountability requirements and in which the resources supporting the position were explicitly linked to volatile elements in the organization's immediate environment. This type of leadership position has been labeled "environmentally dependent." In order to contrast the environmentally dependent leadership position's impact on organizational strategic response (OSR) with an environmentally independent leadership position's impact on OSR, it was necessary to locate comparable organizations that had top leadership occupying an "independent" leadership position, i.e., a leadership position in which there was little or no accountability requirements, and in which the resources necessary to support the position were

not explicitly linked to elements in the organization's environment.

The hypothesis was tested in twelve different partnership outpatient mental health centers in Massachusetts. I attempted to locate an equal number of clinics with dependent and independent leadership positions. In order to locate an adequate sample of clinics, I sent a letter to every partnership clinic director in Massachusetts (See Appendix D) explaining the purpose of the study, the criteria that I intended to use, and informing them that the letter would be followed by a telephone call.

In some cases I was never able to reach anyone at a clinic, despite making up to half a dozen phone calls. In other cases directors were both enthusiastic and willing to assist me but lacked the required tenure in office and therefore did not have the requisite information available to me. The twelve clinics that comprised the final sample consisted of every clinic in Massachusetts that had stable leadership tenure during the period from 1976 - 1980 and that would agree to participate in the study.

While the initial proposal specified that half the clinics would have dependent leadership and half would have independent leadership, the final sample revealed six different leadership categories that I combined into three

categories that included the original dependent and independent labels, and a third leadership type that I labeled jointly funded. (The six different categories that emerged and the rationale for reducing them to three can be found in Chapter IV of this study). A jointly funded leadership category was defined as one in which the top leadership position(s) were funded by both the Department of Mental Health (DMH) and a local Board of Directors (BOD). As it turned out, the clinics were evenly distributed among the three leadership categories: dependent, independent, and jointly funded.

The rationale for the use of partnership outpatient clinics as an experimental population is presented later in this chapter under the heading "Population and Experimental Methods."

This study was designed to test a leadership model that posits a relationship between the organization's environment, the top leadership position in the organization, and the organization's response to environmental change. The hypothesized relationship is based on the degree of environmental dependency associated with the top leadership position.

The study grew out of the following initial speculations about the relationship between leadership dependency and organizational strategic response to change.

RELATIONSHIP 1

An organization with a leader who is dependent on the environment will be more likely to select an organizational strategic response that reflects a high level of responsiveness to environmental changes.

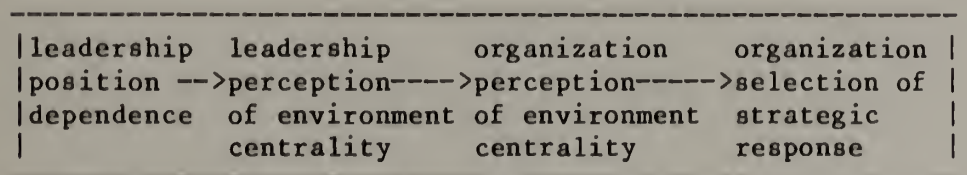
RELATIONSHIP 2

An organization with a leader in an independent position is more likely to select a response that reflects a low level of responsiveness to environmental changes.

The relationship between the variables is diagrammed in Figure 3.

FIGURE 3

THE OVERALL RELATIONSHIP



THE RESEARCH HYPOTHESIS

Controlling for organization size, there is a significant difference in organizational strategic response between organizations with DMH leaders and organizations with BOD leaders, such that organizations with dependent leaders will exhibit

a significantly lesser amount of organizational strategic response (OSR) to externally initiated change, while organizations with DMH leaders will exhibit a larger amount of OSR. Clinics with shared leadership will fall somewhere in the middle.

Design

This study attempted to test the model of leadership dependency by comparing the response of clinic leadership employed by local boards of directors versus state civil service employed leadership to external environmental changes by measuring the organizational strategic response of the clinics that they led. The fact that the sample included a third leadership category (jointly funded) that was not accounted for in the original hypothesis, added a complexity to the final analysis of the data that is explored in some depth in Chapter IV of this study.

The study was conducted in twelve mental health partnership outpatient clinics and the amount of organizational change was determined by comparing individual clinic data from 1976 against the same organizational variables from 1980. The dependent variables measured in this study were: change in the number of programs serving the chronic population; change in the size of the agency budget allocated to serving the chronic population; degree of cooperation between the local DMH area office and the

clinic; change in the average agency length of treatment; change in the percentage of agency treatment time spent in group psychoanalytic methods; change in percentage of agency funds derived from contracts with DMH; attitude toward monitoring clinical staff productivity; change in percentage of agency budget allocated to administrative overhead; change in percentage of agency funds derived from third party payors.

These variables were selected as a result of a series of preliminary study interviews that were held with mental health practitioners throughout Massachusetts. A discussion of this preliminary research and a review of the mental health environment in Massachusetts from 1976 - 1980 can be found in Chapter IV of this study.

Data used in the final study were collected through interviews with clinic directors supplemented when necessary by phone conversations with the clinic's business manager and clinic records.

The decision to conduct the study in mental health clinics was the result of the researcher's extensive personal experience in this system, coupled with the fact that between 1976 and 1980 these clinics faced major environmental changes, and were therefore under enormous pressure to change in response to them.

The primary independent variable in this study was termed leadership position category, defined by the accountability requirements of the position, and labeled independent (I), dependent (D), or jointly funded (JF). In outpatient mental health partnership clinics, there are three major situations that possess the characteristics that can be labeled dependent, independent or jointly funded.

The original hypothesis stated that clinics with leaders who were in the dependent leadership category would exhibit a greater amount of organizational response to the environment than those clinics with a leaders who occupied an independent leadership category. When the final sample revealed a third leadership category that I labeled, jointly funded, I hypothesized that the third jointly funded category would exhibit a response to environmental change that would fall somewhere in the middle of the independent and dependent response. The final results of the study indicated that this was not the case, and jointly funded clinics exhibited significantly less change in response to the environment than either dependent or independently labeled clinics. The reasons for this unexpected outcome are explored in Chapter IV.

Operationalizing the Independent Variables

This study focused on two independent variables. The first, leadership dependency has been discussed at some length. The second, organization size, has not been discussed previously. It was included in the study because I hypothesized that organizational size could be a critical factor in determining organizational response to the environment, interacting with leadership dependency to alter the predicted results. The reasons for this concern are explored later in this chapter.

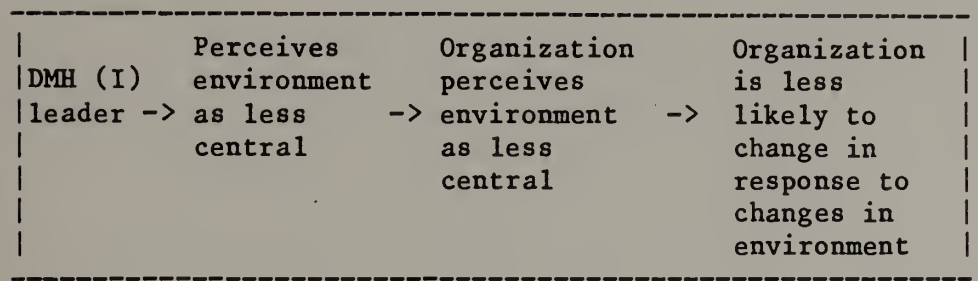
Because it is not intuitively obvious why a civil service leadership position is more independent of the environment than a BOD leadership position, Chapter IV of this study explains in greater detail the management structure of the DMH bureaucracy and its impact on civil service DMH leaders running outpatient mental health centers in the field.

Historically, DMH (Civil Service) leaders did not answer to a local authority but rather to a large and cumbersome state bureaucracy with few controls on its field personnel. The assumption being tested here is that they therefore perceived their positions to be more independent of external accountability and resource requirements than did the BOD leaders, whose jobs were thought to more

directly depend on the agency meeting explicit performance requirements established by funders. A consequence of this perception is that DMH leaders were more likely to perceive the organizational environment as unimportant. The DMH leader's perceptions were then passed along to the organization, resulting in an agency that was significantly less willing to change organizational structural variables and procedures in response to changes in the external environment. This relationship is illustrated in the following figure.

FIGURE 4

DMH LEADERSHIP AND ORGANIZATION RESPONSE



In contrast, the BOD leader reported directly to a governing board made up of local citizens for whom both the clinic and its director were geographically accessible. The accessibility of the BOD leader was compounded by the fact that she or he (along with the Board of Directors) was usually directly involved in the annual fundraising and contracting efforts necessary to maintain her or his salary

as well as keep the clinic itself operating.

Thus this study assumed that the BOD leader was in a very different fiscal position from the DMH leader who was part of a large bureaucracy that was able to insulate its members from the environmental pressures resulting from annual fundraising efforts.

This assumption was based upon the number of bureaucratic layers that existed between the Commissioner of Mental Health, who negotiated with the Massachusetts legislature for funds, and the DMH civil servant leader who collected a paycheck supported by those funds. These layers were extensive enough to act as a buffer zone that protected the DMH civil servant leader from being as concerned about the nature of the fundraising process as the BOD leader. In addition, the existence of a Union for DMH civil service employees, provided some additional protection from the vagaries of the annual legislative funding process.

On the other hand, the study theorized that the BOD leader, would be more likely to perceive her or his position as dependent upon factors in the environment, leading the BOD leader to perceive the environment as relatively more important to the organization.

The relationship is diagrammed in Figure 5.

FIGURE 5

BOD LEADERSHIP AND ORGANIZATION RESPONSE

BOD (D) leader ->	Leader perceives environment as central ->	Organization perceives environment as central ->	Organization is more likely to change in response to environmental changes

Organization Size, The Secondary Independent Variable

Larger organizations are more likely to have an increased ability to (1) resist environmental pressure to change, and (2) access new resources as they become available in the environment (Galbraith, 67; Hannan & Freeman, 77; Aldrich, 79), thereby altering the effect of environmental change on organizational structural variables in ways not accounted for by the leadership dependency model. This study attempted to control for the amount of variance due to clinic size by selecting clinics from a range of sizes. Problems in obtaining a sample made it difficult to obtain an optimal amount of diversity in clinic size, but there was enough range to make some comparisons between smaller and larger clinics.

The size of the organization was be measured by the number of employees and total agency budget in 1976. The researcher collected data on both these variables to determine if they were highly correlated. The degree of correlation was adequate to determine that either one was an acceptable determination of size and so budget size was ultimately used as the variable. A lengthier discussion of the actual data collected on size and budget in 1976 in the twelve clinics can be found in Chapter V.

Most empirical research on organization size has focused on the impact of size on internal variables such as organizational complexity and formalization (Hall, 68; Greiner, 72). There is, however a smaller body of research that examines the effect of organization size on the organization's ability to control its external environment (Katz & Kahn, 66; Thompson, 67). Available data suggest that larger organizations may be more capable of controlling their environments, thereby reducing environmental sources of risk and uncertainty (Caves, 72; Samuels & Smith, 68).

The fact that larger organizations may be more capable of controlling their environments could have two opposite effects on organizational change in the clinics under study. On the one hand, a large organization may be in a better position to resist pressure to change because it does exert a greater amount of control over its external environment.

On the other hand, a large organization that has made a decision to grow and change is in a better position to command the resources from the environment necessary to achieve those goals. In either case, the larger organization is likely to have a different rate of resource acquisition than the smaller organization, based on factors other than leadership dependence.

The Dependent Variable

The study collected data on nine different organizational change measures. Each change measure was assigned four values that reflected the researchers best estimate of the range of possible responses for that particular measure. Identification of the nine organizational change measures and the range of values assigned to each one was the result of preliminary research conducted prior to the formal data collection period and described in the next chapter.

This initial research, coupled with the researcher's own knowledge of the field from being a clinic director during a part of the period included in the study, resulted in the creation of nine organizational change measures. These were termed organizational strategic responses (OSR)

in this study. The change measures or OSRs were assessed in response to stimuli originating in the external environment, hence the term organizational strategic response. The environmental stimuli that triggered (or failed to trigger) the OSRs that comprise the dependent variable in this study, were described in the preceding chapter.

Making the Dependent Variables Operational.

This study attempted to explicitly link environmental change with organizational strategic response. The literature of managerial response to organizational change provided a framework within which to categorize types of organizational strategic response. Responses to change exist on a continuum that ranges from active seeking of change to active prevention of change from entering the organization (Miles, Snow & Pfeffer, 74; Whetten, 80).

Adapting these categories to organizational strategic response, we have the following four categories (1) enthusiastic acceptance, (2) cautious analysis, (3) defensive reaction, and (4) active resistance. The leadership dependence model would then posit that the more dependent the leadership position, the more likely it is that the organization will have a response that represents a

more enthusiastic acceptance of change.

The organizational strategic response categories do not identify the 'right' or appropriate response to an environmental stimulus. Organizations that survive do so because they respond appropriately to environmental changes (Thompson, 67; Meyer, 75; Aldrich, 79), and appropriateness of response can only be determined by hindsight. Thus, all organizations that survive have responded appropriately. Any attempts to identify the 'right' organizational strategic response will lead to this tautology. Therefore, in applying the above cited categories to organizational response strategies utilized in a field study, the researcher is prepared to acknowledge that there are many different criteria against which a selected response can be evaluated: clinical, financial, philosophical, long term and short term.

The model only states that an organization that perceives its environment to be central will be more sensitive to environmental pressures and more willing to change the organizational goals and structure in response to those pressures.

The following listing describes the specific organizational strategic responses that it is hypothesized that each clinic would have made in response to those

environmental stimuli. Under each OSR is listed an operational definition of each of the four possible response categories. Because this was a first attempt to make operational the variables the comprise the model, the discussion of the results of this initial testing of the model will also include a discussion of the validity of these operational definitions of the four response categories.

1. Change in the number of programs that specifically address the needs of the chronic population.
   (a) Increase of two or more in the number of programs (enthusiastic acceptance response).
   (b) Increase of one in the number of programs (cautious analysis).
   (c) No change in the number of programs (defensive reaction).
   (d) Reduction in the number of programs (active resistance).
2. Change in size of agency budget allocated to programs serving the chronic population.
   (a) Increase of 25% or more (enthusiastic acceptance).
   (b) Increase of 15 - 24% (cautious analysis).
   (c) Increase of 5 - 14% (defensive reaction).
   (d) Increase of less than 5% (active resistance).
3. Degree of cooperation between Massachusetts DMH area office personnel and the clinic. Measured by the frequency of

meetings between clinic and area office personnel held monthly, and the climate of those meetings as described by clinic staff.

(a) Minimum of two meetings per month (enthusiastic acceptance).

(b) Minimum of one meeting per month (cautious analysis).

(c) Less than six meetings annually (defensive reaction).

(d) Meetings regardless of frequency are hostile in nature (active resistance).

4. Reduction in average agency length of treatment period.

(a) Reduction by 25% in average agency length of treatment time (enthusiastic acceptance).

(b) Reduction by 15 -24% in average agency length of treatment (cautious analysis).

(c) Reduction by 5- 14% (defensive reaction).

(d) Reduction by less than 5% (active resistance).

5. Reduction in percentage of agency treatment time spent in individual or group psychoanalytic methods.

(a) Reduction by 25% (enthusiastic acceptance).

(b) Reduction by 15 -24% (cautious analysis).

(c) Reduction by 5- 14% (defensive reaction).

(d) Reduction by less than 5% (active resistance).

6. Reduction in percentage of agency funds derived from contracts with DMH.

(a) Increase of 45% or more (enthusiastic acceptance).

(b) Increase of 30 - 49% (cautious analysis).

(c) Increase of 10 - 29% (defensive reaction).

(d) Less than 10% increase (active resistance).

7. Attitude toward monitoring clinical staff productivity. Measured by existence of information system to monitor productivity and existence of productivity standard in the agency.

   (a) Existence of manual or computerized management information system (MIS) and staff productivity requirement (enthusiastic acceptance).

   (b) Plan for an MIS and staff productivity standards in existence (cautious analysis).

   (c) No plans for an MIS or to establish staff productivity requirements (defensive reaction).

   (d) Actively opposed to any system for monitoring staff productivity and any productivity requirement.

8. Reduction in percentage of agency budget allocated to administrative overhead.

   (a) Increase of 25% or more (enthusiastic acceptance).

   (b) Increase of 15 - 24% (cautious analysis).

   (c) Increase of 5 - 14% (defensive reaction).

   (d) Less than 5% increase (active resistance).

9. Change in percentage of agency funds received from third party payors.

   (a) Increase of 100% or more (enthusiastic acceptance).

   (b) Increase of 75 - 99% (cautious analysis).

   (c) Increase of 50 - 74% (defensive reaction).

   (d) Less than 50% increase (active resistance).

For each agency, a composite score ranging from 9 - 36 points was possible. The score was reached in the following manner: (1) each response in each category was worth one point; responses in the "a" or enthusiastic acceptance response category were multiplied times four; (3) all responses in the "b" category or cautious analysis response were multiplied times three; (4) all responses in the "c" or defensive reaction category were multiplied times two; and (5) all responses in the "d" or active resistance category were multiplied times one.

Those clinics with a predominance of ´enthusiastic acceptance´ responses would score toward the higher end of the scale, indicating that they were very responsive to externally initiated change, and, if the hypothesis were correct, were more likely to have an environmentally ´dependent´ leader (BOD funded). Those clinics on the other hand that scored lower on the scale, with more defensive reaction responses, would indicate that they had been resistant to environmentally initiated change. Here again, the leadership dependency model hypothesizes that a clinic with a low score is more likely to have an environmentally independent leader, which as empirically tested in this study, would mean a DMH leader (original hypothesis) or a Jointly Funded leader (alternative hypothesis).

The actual data collected from the clinics did point out weaknesses in the operational definition of OSR. These weaknesses are examined in at some length in Chapter IV of this study.

Operational Definition of the Four Categories of OSR

For purposes of comparison, the listing that follows groups the nine OSR's according to their appropriate response category.

A. Enthusiastic Acceptance Response (Measured by):
   1. An increase of two or more in the number of programs that specifically address the needs of the chronic population.
   2. Increase of 25% or more in percentage of agency funds allocated to programs serving the chronic population.
   3. High degree of cooperation between the clinic and the area office (measured by a minimum of two meetings per month between both agencies).
   4. Reduction by 25% or more in average agency length of treatment time.
   5. Reduction by 45% or more in percentage of agency treatment time spent in individual or group psychoanalytic method.

6. Increase by 45% or more in percentage of agency funds derived from contracts with DMH.
7. Existence of manual or computerized management information system to monitor staff productivity.
8. A 25% or greater increase in percentage of agency budget allocated to administrative overhead.
9. A 100% or greater increase in percentage of agency funds received from third party payors.

An Enthusiastic Acceptance response to all nine OSRs could have produced a total score of 36 points.

B. Cautious Analysis Response (Measured by):

1. An increase of one in the number of programs that specifically address the needs of the chronic population.
2. An increase of 15 - 24% in percentage of agency funds allocated to programs serving the chronic population.
3. A Moderate degree of cooperation between the clinic and the area office measured by a minimum of one meeting per month between both agencies.
4. A reduction by 15% - 24% in average agency length of treatment time.
5. A reduction by 30- 49% in percentage of agency treatment time spent in individual or group psychoanalytic method.

6. An increase by 30 - 49% in percentage of agency funds derived from contracts with DMH.
7. Plans for a manual or computerized management information system to monitor staff productivity.
8. A 15 - 24% increase in percentage of agency budget allocated to administrative overhead.
9. A 75% - 99% increase in percentage of agency funds received from third party payors.

A Cautious Analysis Response to all nine OSRs could have produced a total score of 27 points.

C. Defensive Reaction Response (Measured by):

1. No change in the number of programs that specifically address the needs of the chronic population.
2. An increase of 5 - 14% in percentage of agency funds allocated to programs serving the chronic population.
3. A Minimum degree of cooperation between the clinic and the area office measured by less than six meetings held annually.
4. A reduction by 5% - 14% in average agency length of treatment time.
5. A reduction by 10 - 29% in percentage of agency treatment time spent in individual or group psychoanalytic method.
6. An increase by 10 - 29% in percentage of agency

funds derived from contracts with DMH.

7. No plans to monitor individual staff productivity.
8. A 15 - 24% increase in percentage of agency budget allocated to administrative overhead.
9. A 75% - 99% increase in percentage of agency funds received from third party payors.

A Defensive Reaction response to all nine OSRs could have produced a total score of 18.

D. Active Resistance Response (Measured by):

1. A reduction in the number of programs that specifically address the needs of the chronic population.
2. Less than a 5% increase in percentage of agency funds allocated to programs serving the chronic population.
3. Meetings between the area office and the clinic are uniformly hostile and confrontational in nature.
4. Less than a 5% decrease in average agency length of treatment time.
5. Less than a 10% decrease in percentage of agency treatment time spent in individual or group psychoanalytic method.
6. Less than a 10% increase in percentage of agency funds derived from contracts with DMH.

7. Active opposition to concept of monitoring individual staff productivity.
8. Less than a 5% increase in percentage of agency budget allocated to administrative overhead.
9. Less than a 50% increase in percentage of agency funds received from third party payors.

A Defensive Reaction response to all nine OSRs could have produced a total score of 9 points.

Each of the individual organizational change variables is assigned four values, each one corresponding to one of the four OSR categories. The study tested whether the selection of a particular category of response was significantly altered by the presence of a DMH employed versus a BOD leader.

Coding and Determining the Significance of the Results.

In order to determine the significance of the relationship that emerged between the independent variable (the independence/dependence of the leadership position) and the dependent variable (the amount of organizational change that occurred between 1976 and 1980), the following coding system was used.

The leadership categories were placed on an ordinal dependency scale from most independent (upon the environment) to most dependent. Thus, in the initial

hypothesis tested, the 'DMH Civil Service' funded Leadership position was placed at the most independent end of the scale and given a score of '1', the Jointly Funded position was placed in the middle of the ordinal scale and given a score of '2', and the BOD Leadership position was placed at the most dependent end of the scale and coded as a '3'.

In the alternative hypothesis, the Jointly Funded leadership position was placed at the most independent end of the scale and coded as a '1', while the DMH leadership position was placed in the center of the ordinal scale and coded as a '2'.

Using a Pearson Product-Moment Correlation calculation, the significance of the results was calculated for both the original and alternative hypothesis.

Sample Selection

The sample consisted of twelve partnership mental health clinics in Massachusetts, out of a total of forty-eight. Because the study required clinics that had the same leader during the period from 1975 - 1980, and because it was necessary to obtain voluntary permission from each potential site in order to include it in the sample, there were a number of problems in assembling a sample population. For a complete list of all the clinics in

Massachusetts, their addresses, and the results of the initial telephone contacts with each one, see Appendix 5.

Ideally, the sample would have consisted of ten clinics that were selected using the following criteria.

1. Five of the clinics would have had stable DMH leadership during the period from 1975 - 1980, and five would have had stable board appointed leadership during the same period of time.

2. Within each set of five clinics, there would have been a wide range in clinic size, and clinic size would have been matched as closely as possible between the two sets.

3. Geographic diversity was a third criteria that would have been considered in sample selection.

In reality, there were significant problems in assembling any sample at all, never mind one that met all of the above listed criteria and the actual sample was only an

approximation of the ideal. Interviews were actually conducted at every clinic that indicated they were willing to participate in the study and also had stable leadership from 1975 - 1980. As previously mentioned, that sample consisted of twelve out of the original forty-eight.

Procedures

The procedures for this study are presented in chronological order.

Data were collected on changes that occurred between 1976 and 1980. This time period was selected for a number of reasons. First of all, this is a period of time in which the researcher already had detailed knowledge of environmental and organizational changes in mental health. Second, this was the period of time in which Robert L. Okin was Commissioner of the Department of Mental Health in Massachusetts, and the commitment to deinstitutionalization and agency decentralization had reached a fever pitch, creating massive changes in the environment of mental health partnership clinics. Third, the lack of administrative sophistication common to many small clinics meant that the systematic accumulation and storage of data about budgetary and staff changes was not always a common practice.

Therefore, the more recent the period of time covered by the study, the more accurate the data were likely to be.

Initially, a letter was sent to the directors of all partnership clinics in Massachusetts (See Appendix 4 for the complete text of the letter). The letter introduced the researcher, provided a brief overview of the study, explained that ten clinics were necessary for the sample, and that sites would be selected based on the following criteria:

(a) stable top leadership from 1976 through 1980

(b) willingness on the part of the clinic to participate.

The letter included a description of the type of information needed in order to do the research, and an estimate of the amount of time required from the participating clinic's staff.

The letter concluded by telling the executive director that it would be followed up by a phone call from the researcher within two weeks, and that the researcher would be happy to provide references, and answer any further questions the executive director might have at that time.

Within two weeks of sending the letter, an attempt was made to contact each clinic director over the phone. For a short description of the response of each clinic, see Appendix 5.

Twelve different sites were identified based on the two criteria listed above and an appointment was made to conduct the interview. It was also determined at that time whether the interview would be conducted with the clinic executive director or whether another person in the clinic would be the interviewee. It is interesting to note that in eleven out of the twelve clinics, the clinic director elected to participate in the interview. In the case of one clinic, the Business Manager of the clinic was the interviewee.

Participating clinics were sent a copy of the data collection instrument and a brief note confirming the interview time and place.

Interviews were then held with the selected clinics. The goal of the interviews was to collect all the necessary data for the study. In some cases the interviews were followed up by phone calls or an additional meeting to fill in gaps in knowledge on the part of the interviewer.

Necessary archival data were collected at some of the interviews, and where possible, copies of critical pieces of written information were made for later review by the researcher.

The data were then analyzed. A written analysis of the results can be found in Chapter IV of this dissertation.

After the dissertation defense, a summary of the results of the study will be mailed to the participating clinics along with a thank you letter for their help.

Rationale for Selection of Interview Method

The decision to approach each clinic individually and collect the data through interviews and a review of written records was based upon preliminary research revealing that there was no reliable aggregate data on partnership mental health clinics in Massachusetts.

In addition, much of the data that were collected in this study were not easily retrievable from traditional documents, such as annual reports or agency budgets. Part of the reason for this problem can be found in the lack of administrative sophistication found in many small partnership clinics, resulting in erratic and non-standardized data collection methods. In addition, in smaller clinics, clinic policies were likely to be informal

and inexplicit because they were based on agency norms that evolved over many years and were passed along through example and word of mouth. In this type of situation the best data collection method was interviews with agency directors in order to retrieve even basic information about agency policy.

An example of the problem of gathering information from summary data can be found by looking at the question of determining the percentage of agency budget allocated to administrative overhead. Different clinics defined administrative overhead differently. In some agencies, the administrative overhead figure included salaries of clerical personnel, while in other clinics the same terms referred only to central management staff. Since the definition of administrative overhead changed from year to year, an accurate assessment of changes in the overhead figure over time could only have occurred by spending time with each individual clinic's director, clarifying these kind of issues.

CHAPTER V

RESULTS AND DISCUSSION

The Leadership Dependency Model

The leadership dependency model posits that there is a relationship between the degree of environmental dependency of the top leadership position in an organization and that organization's response to environmentally initiated change. Environmental dependency has been defined as the degree of environmental accountability of the leadership position, and the degree of dependence of the leadership position on external funding sources. In this study the relationship between environmental dependency and organizational response was made operational in the following hypothesis:

> Controlling for size, the partnership mental heath clinic with a director who is employed by a local board of directors, will have a significantly higher organizational change score than the organization with a civil service appointed clinic director.

As will be evident in the presentation of results and discussion which follows, the study produced some interesting findings in relation to the hypothesis. However, equal in importance to these findings, was the

information gained making the variables operational.

The following sections first address findings related to the operationalizing of the variables. As had been hinted at earlier, some surprises were found which will influence future research on the leadership dependency model. At the end of the chapter findings regarding the main hypothesis are presented.

Interviews were conducted at twelve clinics. Contrary to the original design, the twelve clinics included in the study were found to have

six different leadership categories, rather than the two categories or DMH leadership and BOD leadership that were originally expected.

The six categories were:

1. Single DMH Funding/Single Leadership (Clinic D,E,H)
2. Single DMH Funding/Shared Leadership (Clinic C)
3. Shared Funding/Single Leadership (Clinics J, L)
4. Shared Funding/Shared Leadership (Clinics A,I)
5. Single BOD Funding/Single Leadership (Clinic F,G,K)
6. Single BOD Funding/Shared Leadership (Clinic B)

In order to better understand the relationship of these six leadership categories to the leadership dependency model, Figure 6 depicts the both the funding source and whether the top leadership position was shared or held by only one person.

FIGURE 6

THE SIX LEADERSHIP CATEGORIES

FUNDING	SINGLE LEADERSHIP	SHARED LEADERSHIP
SINGLE	D, E, H	C
BOD	F, G, K	B
SHARED	J, L	A, I

The variety of leadership categories that were encountered reflected the decentralized nature of the DMH clinic governance structure and may well have represented a type of organizational strategic response (OSR) that each organization had made to adapt to the volatile external environment.

In terms of the hypothesis, the variety of leadership categories still had implications for where the clinics were likely to fall on the independent versus dependent leadership scale. Table I indicated where the six different

leadership categories were placed on the independent/dependent continuum. Note that the six categories were combined into three categories consisting of two each from the original six.

TABLE 1

PREDICTION OF INDEPENDENT/DEPENDENT LEADERSHIP POSITION CHARACTERISTICS AND THE IMPACT OF THOSE CHARACTERISTICS ON ORGANIZATIONAL CHANGE

MOST INDEPENDENT OF THE ENVIRONMENT <----		----> MOST DEPENDENT ON THE ENVIRONMENT
FOUR CLINICS	FOUR CLINICS	FOUR CLINICS
CLINICS C,D,E, & H)	CLINICS A,I,J, & L	CLINICS B,F,G, & K)
LEADERSHIP CAT. 1 & 2 (Independent)	LEADERSHIP CAT. 3 & 4 (Jointly Funded)	LEADERSHIP CAT. 5 & 6 (Dependent)

Leadership Categories 1 and 2, single DMH funding with both single and shared leadership (Clinics C, D, E, and H), met the criteria of having a single external and geographically removed source controlling the top leadership position(s). While shared leadership will alter dynamics inside the organization, the fact that both leaders are accountable to the same external source, DMH, reflects the most critical component of the leadership dependence model,

which is the accountability requirements attached to the leadership position by the external factors that fund and therefore control the position.

In the same way, those clinics in leadership categories 5 and 6, (Clinics, B,F,G, and K), single BOD funding, single and shared leadership, were still defined as dependent because the external funding and accountability requirements attached to the leadership position(s) were all emanating from the local Board of Directors. Thus the accountability requirements attached to the leadership position(s) should not alter.

Those clinics in leadership categories 2 and 3, with shared funding of the top leadership position(s) (Clinics A, I, J, and L), were clearly more problematic in respect to the model. Initially, I speculated that the presence of two different funding sources would produce countervailing pressures on the organization that could lead to a compromise solution in respect to the amount of environmental change that entered the organization. As a result the shared funding could produce a middle-of-the-road change strategy resulting from compromises that occurred as a result of the leader's attempts to balance BOD pressure to change with the traditional independence of the DMH funded position. Consequently, those clinics with shared funding of the top leadership position were placed in

the middle of the independent/dependent scale.

It should be noted here that the results of the study necessitated a review of the placement of Joint Programs in the middle of the scale. The findings led to an alternative hypothesis that placed the Jointly Funded clinic leadership category at the most independent end of the scale. This change in placement is examined in depth in the conclusion section of this chapter.

Making the Independent Variable Operational

The study originally proposed that there would be two independent variables, one labeled independent (I), in the case of the DMH funded leadership position, and one labeled dependent (D), in the case of the BOD funded leadership position. The actual sample revealed the need for a third independent variable that was labeled jointly funded (JF).

The final sample contained four clinics in each of the three leadership categories: four Independent (I) Leadership category clinics (C, D, E, and H); four Dependent (D) Leadership category (B, F, G, and K); and four Jointly Funded (JF) Leadership category clinics (A, I, J, and L).

Size, The Secondary Independent Variable.

The size of the organization was measured by the number of employees and total agency budget in 1976. Data were collected on both these variables in order to determine which would be the better measure of size. The intent was to determine if the variables were highly correlated, and, if that were the case, to discard one.

The following is a listing of clinics followed by their 1976 staff and budget size. The clinic leadership category is also presented in the table in order to ease comparison on this variable (Independent [I], Dependent [D], and Jointly Funded [JF]).

TABLE 2

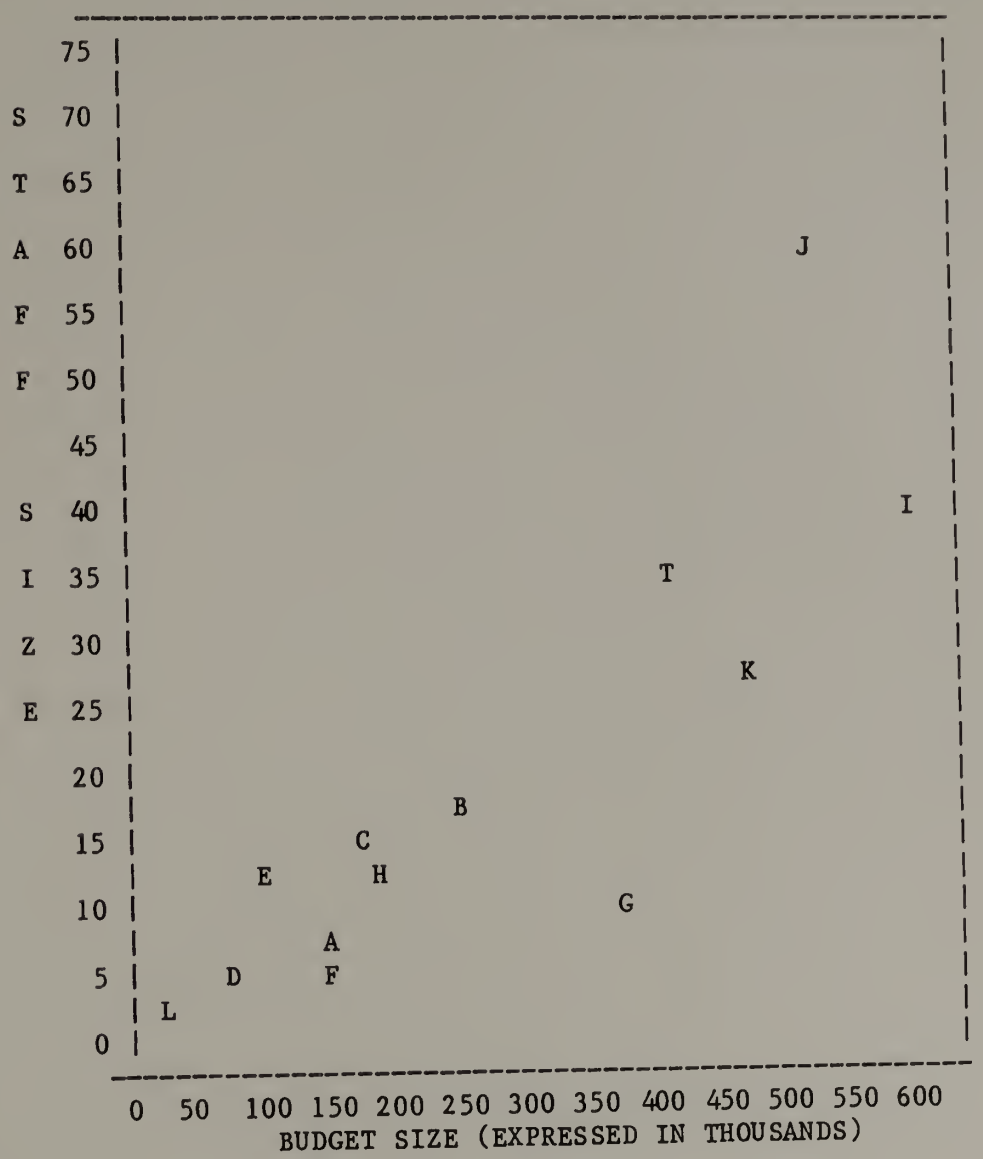
1976 STAFF, BUDGET SIZE,
AND LEADERSHIP CATEGORY OF THE CLINICS

CLINIC	STAFF	BUDGET	LEADERSHIP CATEGORY
A	7.5	150,000	JF
B	17	241,000	D
C	14.5	177,000	I
D	4	71,000	I
E	11.5	112,000	I
F	6	155,000	D
G	9	400,000	D
H	11.5	160,000	I
I	40	600,000	JF
J	60	532,000	JF
K	27	497,000	D
L	3	38,000	JF

The following scatterplot illustrates the relationship between staff size and budget size for the clinics.

FIGURE 7

RELATIONSHIP BETWEEN STAFF AND BUDGET SIZE IN 1976



The scatterplot indicates a positive relationship between staff size and budget size. In a Pearson Product-Moment correlation, r-squared equalled .690, with a significance level of less than .001 ($p < .001$).

The original research design stated that the study would "control" for clinic size. However, the small sample that comprised this study made it difficult to extract anything of significance from a hierarchical multiple correlation equation. A series of simple correlations of clinic size (using budget in 1976) with (1) the number of miles the clinic was from the DMH central office, (2) the three leadership categories (in an ordinal scale where I =1, JF = 2, and D =3, representing their place on the Independent- Dependent continuum) and (3) the final OSR scores, indicated that size was completely uncorrelated with any of those variables. As a result I concluded that clinic size had no impact on the study results. The statistics supporting this statement can be found in Appendix F, "Supplemental Statistical Data for Chapters IV and V".

Geographic Diversity

The study attempted to seek out clinics in geographically diverse areas and, in general succeeded. The locations of clinics are depicted in Table 3.

TABLE 3

GEOGRAPHIC DISTRIBUTION OF SAMPLE

NO. SHORE	BOSTON	SO. SHORE	CAPE COD	MID. MASS	WEST. MASS
C, G	A,I,K,F	B,D	H,L	J	E

In general this distribution is representative of the location of all the partnership clinics in Massachusetts, which are show in Table 4.

TABLE 4

GEOGRAPHIC DISTRIBUTION OF ALL CLINICS

NO. SHORE	BOSTON	SO. SHORE	CAPE COD	MID. MASS	WEST. MASS
5	22	4	3	4	10

This chart indicates that Western Massachusetts was somewhat underrepresented in the sample group studied. At the time the study was conducted clinics in Western Massachusetts were still under enormous pressure as a result of the Consent Decree, and clinic directors contacted were either recently appointed, or else felt that the ongoing pressures of the Consent Decree prevented them from becoming involved in assisting in this study. While the under

representation of the western Massachusetts area was a minor problem in overall geographic diversity of the sample, it created a significantly greater problem when the sample was broken out according to type of leadership (Independent, Dependent and Jointly Funded). The following chart indicates the problem.

TABLE 5

GEOGRAPHIC DISTRIBUTION OF SAMPLE CLINICS

BY LEADERSHIP TYPE

	NO SHORE	BOSTON	SO SHORE	CAP COD	MID MASS	W. MA.
Dep.			B,D	H		E
JF		A,I		L	J	
Ind	C,G,	F,K				

While Independent Clinics are clustered in the greater Boston area near the DMH Central Office (which is located in the North End of Boston placing it considerable closer to the North Shore than it is to the South Shore), the Dependent Clinics all tended to be located at a greater distance from Boston. While the relationship between Leadership category and miles from DMH Central Office was marginal (R-Squared = .3485, $p < .04$), it was potentially a problem since one basis for the argument that DMH leaders were more independent of their environment than BOD leaders

was that the geographic as well as bureaucratic centralization of the DMH made it difficult to hold them accountable. Therefore, it is possible that BOD leaders of clinics that are geographically close to the central DMH office were subjected to a greater amount of pressure to respond to central office imperatives than clinics that were located further away from Boston. It was unfortunate that I was unable to get permission to conduct the study at some clinics with Independent leadership that were located at a greater distance from Boston.

The Dependent Variables or Organizational Strategic Responses

The dependent variable in this study was actually a composite of nine different organizational change variables. The following section includes tables that illustrate the responses to each of the nine organization change variables (which were termed Organizational Strategic Responses [OSR] in this study). This section concludes with a table depicting the composite OSR score for each clinic.

Preceding each table illustrating each clinic's response, is a description of the organizational change and a listing of the four possible OSR's. Problems that emerged in the operationalization of at least some of the OSRs will be noted in the following section.

1. Change in the number of programs that specifically address the needs of the chronic population.
   (a) Increase of two or more in the number of programs (enthusiastic acceptance response).
   (b) Increase of one in the number of programs (cautious analysis).
   (c) No change in the number of programs (defensive reaction).
   (d) Reduction in the number of programs (active resistance).

This Organizational Strategic Response (OSR) suffered less from a subjective interpretation by the interviewee than did many of the questions that were asked in the interview. In general there was a common perception of a "chronic client" and, because DMH had been both funding and promoting programs specifically for this population, there was a clear shared perception of the kind of information wanted.

The spread of the answers, illustrated in Table 6, indicates that the question provoked a range of responses, and did a good job of differentiating between clinics as a measure of organizational change.

TABLE 6

CHANGE IN THE NUMBER OF PROGRAMS
FOR THE CHRONIC CLIENT

CLINIC	PROGRAMS 1976	PROGRAMS 1980	CHANGE CATEGORY
A	0	0	DR
B	1	4	EA
C	0	2	EA
D	0	2	EA
E	1	1	DR
F	0	7	EA
G	0	9	EA
H	2	2	DR
I	1	0	AR
J	1	1	DR
K	2	5	EA
L	0	1	CA

TOTALS: 6 ENTHUSIASTIC ACCEPTANCE (B,C,D,F,G,K)
1 CAUTIOUS ANALYSIS (L)
4 DEFENSIVE REACTION (A,E,H,J)
1 ACTIVE RESISTANCE (I)

2. Change in size of agency budget allocated to programs serving the chronic population.

   (a) Increase of 25% or more (enthusiastic acceptance).

   (b) Increase of 15 - 24% (cautious analysis).

   (c) Increase of 5 - 14% (defensive reaction).

   (d) Increase of less than 5% (active resistance).

It was expected that the response to the question of agency budget would not be very different from the response to the question about growth in number of programs. And in most cases a growth in the number of programs serving the

chronic client was accompanied by an equivalent growth in budget size. The major difference between the two OSRs was in the increase in the Active Resistance group - In the OSR that dealt with number of programs for chronic clients there was only one clinic that had an AR response; when the OSR dealt with budget allocations to the chronic population, the number of AR responses jumped to four clinics.

This could reflect the fact that some clinics were willing to pay "lip service" to the needs of the chronic population by establishing small and underfunded programs in this clinics, but had not substantially altered the flow of dollars to address the needs of this population. The responses are presented in Table 7.

TABLE 7
CHANGE IN PERCENTAGE OF AGENCY BUDGET
ALLOCATED TO PROGRAM FOR THE CHRONIC CLIENT

CLINIC	PROGRAMS 1976	PROGRAMS 1980	CHANGE CATEGORY
A	70%	75%	DR
B	5%	30%	EA
C	5%	16%	DR
D	5%	5%	AR
E	100%	60%	AR
F	15%	50%	EA
G	0%	40%	EA
H	20%	50%	EA
I	15%	10%	AR
J	20%	40%	CA
K	29%	58%	EA
L	5%	5%	AR

TOTALS: 5 ENTHUSIASTIC ACCEPTANCE (B,F,G,H,K)
1 CAUTIOUS ANALYSIS (J)
2 DEFENSIVE REACTION (A,C)
4 ACTIVE RESISTANCE (I,D,E,L)

3. Degree of cooperation between Massachusetts DMH area office personnel and the clinic. Measured by the frequency of meetings between clinic and area office personnel held monthly, and the climate of those meetings as described by clinic staff.

   (a) Minimum of two meetings per month (enthusiastic acceptance).

   (b) Minimum of one meeting per month (cautious analysis).

   (c) Less than six meetings annually (defensive reaction).

   (d) Meetings regardless of frequency are hostile in nature (active resistance).

The response to the question of relationship with the area office represented a problem that characterized all nine components of the dependent variables in this study. In an effort to quantify the responses as much as possible, the relationship between the clinic and the area office was measured by the number of meetings per month. Unfortunately, as Table 8 indicates, this measure indicated that nine out of the twelve clinics had excellent relationships with their area office. My own experience, supported by the discussions that accompanied the interview, disputes the fact that nine out of the twelve really had excellent relationships. It is probable in this case that the number of meetings per month failed to reflect the quality of the relationship between the DMH Area Office and the clinic. In this case the objective measurement failed to differentiate adequately between the different clinics.

Another problem that this particular variable reflected is the limitations associated with interviewing only the Director of the Clinic. A better measure of the relationship might have been arrived at by interviewing the local DMH Area Office Director, as well as the clinic Director and arriving at a qualitative description of the relationship.

On the other hand, requests for an evaluation of the relationship of the two parties might have led to answers that were more politic than accurate. While a few clinic directors were unabashedly honest in their evaluations of their own clinics and the external agencies with which they dealt, most were sensitive to their agency representative roles and I felt that they were choosing their descriptions with care when talking about these critical relationships with an outsider.

Consequently, I perceived that there was a "flattening" effect in the clinic directors' descriptions of the ups and downs that characterized the organizations cycles in their agencies. The reason for this flattening effect may have its origin in the fact that a clinic director has a vested interest in portraying the organizational changes in her or his own clinic as a rational and planned process, and thus minimize unpredictable and dramatic changes that were the result of serendipity or other forces beyond the control of the clinic management. As a result, there may have been a tendency to underestimate the importance of negative events, and explain away positive events with rational explanations gained from hindsight. This tendency might explain the "flattening " of a number of the OSRs, so that the clinics seemed to all group in a single response area.

TABLE 8

DEGREE OF COOPERATION BETWEEN
DMH AREA OFFICE AND CLINIC

CLINIC	MEETINGS PER MO 1976	MEETINGS PER MO 1980	CHANGE CATEGORY
A	0	2	EA
B	1	0	AR
C	1	3	EA
D	4 Per Year	4	EA
E	2	1	CA
F	2	2	EA
G	4	4	EA
H	4	4	EA
I	4	4	EA
J	0	2	EA
K	4	4	EA
L	4	1	DR

TOTALS: 9 ENTHUSIASTIC ACCEPTANCE (A,C,D,F,G,H,I,J,K)
1 CAUTIOUS ANALYSIS (E)
1 DEFENSIVE REACTION (L)
1 ACTIVE RESISTANCE (B)

4. Changes in average agency length of treatment period.

(a) Reduction by 25%: EA.

(b) Reduction by 15 -24%: CA.

(c) Reduction by 5- 14%: DR

(d) Reduction by less than 5%: AR.

The wide range of responses to this particular variable (6 EA versus 5 AR) illustrated in Table 9 reflects the fact that several clinics in 1976 (the base period) had already begun to utilize a shorter length of treatment period, so they exhibited little change between 1976 and 1980. On the other hand, Clinic G which dropped only from 9 months to 7 months between 1976 and 1980, was labeled an EA response.

Clearly the shift from long-term psychoanalytic kinds of treatment to short-term, behavioral kinds of intervention had begun in many clinics prior to 1976. In this case factors preceding the changes that occurred during the Okin administration had already begun to effect major changes in treatment philosophy and methodology in a number of clinics. As a result, this particular OSR was not an accurate measure of organizational change during the period from 1976 - 1980.

TABLE 9

CHANGE IN AVERAGE LENGTH OF TREATMENT

CLINIC	LENGTH OF TREAT 1976	LENGTH OF TREAT 1980	PERCENT CHANGE	CHANGE CATEGORY
A	8 MO	5 MO.	38%	EA
B	12 MO	2 MO.	83%	EA
C	6 MO	6 MO.	0%	AR
D	9 MO	9 MO.	0%	AR
E	8 MO	6 MO.	25%	EA
F	3 MO	3 MO.	0%	AR
G	9 MO	7 MO.	29%	EA
H	3 MO	3 MO.	0%	AR
I	5 MO	4.5 MO.	10%	DR
J	24 MO	3 MO.	88%	EA
K	9 MO	3.5 MO.	55%	EA
L	3 MO	3 MO.	0%	AR

TOTALS: 6 ENTHUSIASTIC ACCEPTANCE (A,B,E,G,J,K)
0 CAUTIOUS ANALYSIS
1 DEFENSIVE REACTION (I)
5 ACTIVE RESISTANCE (C,D,F,H,L)

5. Change in percentage of agency treatment time spent in individual or group psychoanalytic methods.

   (a) Reduction by 25%: EA.

   (b) Reduction by 15 -24%: CA.

   (c) Reduction by 5- 14%: DR.

   (d) Reduction by less than 5%: AR.

While this OSR demonstrated a good spread on the responses, and while I tend to trust the estimates about the amount of change that occurred (or failed to occur) in the percentage of psychoanalytic treatment offered between 1976 and 1980, the highly subjective interpretation of the term"psychoanalytic treatment" made it difficult to assume that each clinic director had the same concept in her or his mind when the question was answered. In several instances clinic directors asserted that psychoanalysis was the basis of all therapy, and therefore it characterized 100% of the treatment methods offered at their clinics. In several other cases the term psychoanalysis produced an immediate and strong negative emotional response, such that I judged it unlikely that the interviewee was providing me with an accurate assessment of the actual use of psychoanalytic methods over time in her or his clinic.

This question would have been clearer if each respondent had been provided with an operational definition of psychoanalytic treatment, (i.e. long-term, insight oriented therapy), in order to insure that everyone was responding to approximately the same concept.

TABLE 10

CHANGE IN PERCENTAGE OF TIME SPENT USING PSYCHOANALYTIC TREATMENT METHODS

CLINIC	PERCENT 1976	PERCENT 1980	PERCENT CHANGE	CHANGE CATEGORY
A	CONTINUING HIGH PERCENTAGE			AR
B	50%	45%	-5%	DR
C	65%	45%	-20%	CA
D	80%	40%	-40%	EA
E	90%	80%	-10%	DR
F	50%	50%	0%	AR
G	75%	10%	-65%	EA
H	50%	25%	-25%	EA
I	90%	90%	0%	AR
J	100%	50%	-50%	EA
K	100%	55%	45%	EA
L	MINOR	MINOR	0%	AR

TOTALS: 5 ENTHUSIASTIC ACCEPTANCE (D,G,H,J,K)
1 CAUTIOUS ANALYSIS (C)
2 DEFENSIVE REACTION (B,E,)
4 ACTIVE RESISTANCE (A,F,I,L)

6. Change in percentage of agency funds derived from contracts with DMH.

(a) Increase of 45% or more: EA.

(b) Increase of 30 - 49%: CA.

(c) Increase of 10 - 29%: DR.

(d) Less than 10% increase: AR.

The response to this OSR reflected lingering hostility on the part of many clinics toward the new and still administratively chaotic DMH contracting procedure. This negative attitude was also the result of a perception on the part of a number of clinic directors that the new

contracting procedure required a significantly greater amount of administrative overhead. At the same time, the contracts reduced local clinic autonomy through the use of strict program requirements written into the contract and enforced through an annual review and renewal of funds.

TABLE 11

CHANGE IN PERCENTAGE OF FUNDS DERIVED FROM DMH CONTRACTS

CLINIC	PROGRAMS 1976	PROGRAMS 1980	PERCENT CHANGE	CHANGE CATEGORY
A	0%	0%	0%	AR
B	4%	64%	60%	EA
C	27%	40%	13%	DR
D	0%	63%	63%	EA
E	45%	45%	0%	AR
F	0%	31%	31%	CA
G	15%	48%	33%	CA
H	UNDER 5%	SAME	0%	AR
I	25%	10%	-15%	AR
J	0%	4%	3%	AR
K	40%	20%	16%	DR
L	66%	40%	-26%	AR

TOTALS:
2 ENTHUSIASTIC ACCEPTANCE (B,D)
2 CAUTIOUS ANALYSIS (F,G)
2 DEFENSIVE REACTION (C,K)
6 ACTIVE RESISTANCE (A,E,H,I,J,L)

7. Attitude toward monitoring clinical staff productivity. Measured by existence of a management information system (MIS) to monitor productivity and, the existence

of a productivity standard in the agency.

(a) Existence of manual or computerized management information system (MIS) and staff productivity requirement: EA.

(b) Plan for an MIS and staff productivity standards in existence: CA.

(c) No plans for an MIS or to establish staff productivity requirements: DR.

(d) Actively opposed to any system for monitoring staff productivity and any productivity requirement: AR.

The ten clinics with an EA response for this OSR probably reflect the tendency described above for the clinic director to be somewhat politic in discussing her or his agency with an outsider. My experience as a clinic director, supplemented by numerous discussions held formally (at Association of Clinic Director's meetings) and informally with other clinic directors is that establishing a productivity requirement and enforcing one are two different things. There is a good chance that a number of the clinics with EA responses have requirements in place that they are not able to enforce due to philosophical concerns about the issue of establishing productivity requirements for a professional, or simple inadequacy of the existing MIS to provide that kind of information.

Still, the data do indicate that there is a definite trend toward an explicit and enforced productivity requirement.

TABLE 12

EXISTANCE OF A MANAGEMENT INFORMATION SYSTEM
AND A STAFF PRODUCTIVITY REQUIREMENT

CLINIC	MIS/ PRODUCTIVITY REQ 1976	MIS/ PRODUCTIVITY REQ 1980	CHANGE CATEGORY
A	MANUAL MO./ 0%	MANUAL WEEKLY/ 50%	EA
B	MANUAL / 0%	MANUAL / 50%	EA
C	NONE / 0%	COMPUTERIZED/ 50%	EA
D	MANUAL / 0%	MANUAL / 0%	DR
E	NONE / 0%	MANUAL / 60%	EA
F	MANUAL / 50%	MANUAL / 50%	EA
G	LIMITED / 0%	MANUAL / 55%	EA
H	NONE / 50%	MANUAL / 50%	EA
I	COMPUTERIZED/0%	COMPUTERIZED/ 60%	EA
J	MANUAL /50%	MANUAL / 50%	EA
K	MANUAL / 0%	COMPUTERIZED/ 50%	EA
L	WEEKLY/ 0%	WEEKLY / 0%	DR

TOTALS: In 1976 only three clinics (F,H,J) had productivity requirements. By 1980 only two did not have any productivity requirements (D,L).

In 1976 only one clinic (I) had a computerized information system. In 1980, three (C,I,K) had computerized systems.

In 1976 three clinics had no information system at all (C,E,H) and one had a limited system (G). By 1980 every clinic had some kind of information system in place.

8. Change in percentage of agency budget allocated to administrative overhead.

(a) Increase of 25% or more: EA.

(b) Increase of 15 - 24%: CA.

(c) Increase of 5 - 14%: DR.

(d) Less than 5% increase: AR.

The fact that no clinic showed an increase of 25% or more (EA) may not so much an accurate assessment of actual changes in overhead over time, as it does the clinic directors' sensitivity to the unsavory reputation that administrative overhead has in the public sector. No matter how necessary administrative overhead may be to successful management, there is a tendency for the tax paying public to view overhead dollars as squeezed out of vital direct service funds in order that agencies can use them in various frivolous and self-indulgent ways.

Consequently the range may appear more condensed in these figures than it is in fact. Clinic directors responsible for defending agency spending to various funding sources, invariably commented during the interview on the sensitivity of this issue. This sensitivity might have resulted in scores that were somewhat lower overall than the reality may have been.

During the interview itself, attempts were made to reduce the potentially subjective nature of the responses by clearly defining all the factors included in overhead (e.g. clerical support staff, central agency staff, agency finance people, the salaries of an DMH people who fill those functions, and physical plant maintenance and non-capital expenditures). As a result of this careful definition of overhead, the clinic directors' were most likely identifying

the same actual cost categories in their percentage estimates.

TABLE 13

PERCENTAGE OF ADMINISTRATIVE OVERHEAD IN TOTAL BUDGET

CLINIC	PERCENT 1976	PERCEMT 1980	PERCENT CHANGE	CHANGE CATEGORY
A	5%	23%	18%	CA
B	15%	12%	-3%	AR
C	5%	16%	11%	DR
D	5%	28%	23%	CA
E	10%	12%	2%	AR
F	20%	30%	10%	DR
G	15%	27%	12%	DR
H	2%	25%	23%	CA
I	28%	20%	-8%	AR
J	9%	20%	11%	DR
K	10%	30%	20%	CA
L	5%	15%	10%	DR

TOTALS:
0 ENTHUSIASTIC ACCEPTANCE
4 CAUTIOUS ANALYSIS (A,D,H,K)
5 DEFENSIVE REACTION (C,F,G,J,L)
3 ACTIVE RESISTANCE (B,E,I)

9. Change in percentage of agency funds received from third party payors.

(a) Increase of 100% or more: EA.

(b) Increase of 75 - 99%: CA.

(c) Increase of 50 - 74%: DR.

(d) Less than 50% increase: AR.

This OSR was one of the most objectively defined and easily measured. Those clinics who received a significant amount of money from this source in 1976 kept careful records, while those that did not keep careful records, did so because so little of their funds were from that source. However, with a few exceptions, third party funding had become an increasingly important part of the agency budget by 1980 and clinics were able to retrieve this data quickly and with great accuracy.

There was a good distribution of responses across the four categories. The fact that there were five clinics with an EA response is not surprising in light of the tripling of retained medicaid reimbursement that occurred during this period.

TABLE 14

PERCENTAGE OF AGENCY FUNDS
FROM THIRD PARTY PAYORS

CLINIC	PROGRAMS 1976	PROGRAMS 1980	PERCENT CHANGE	CHANGE CATEGORY
A	29%	43%	14%	DR
B	2%	50%	48%	EA
C	2%	18%	16%	CA
D	30%	60%	30%	EA
E	40%	43%	39%	EA
F	10%	35%	25%	EA
G	15%	25%	10%	DR
H	2%	5%	3%	AR
I	32%	43%	11%	AR
J	53%	13%	-40%	AR
K	5%	40%	35%	EA
L	5%	10%	5%	DR

TOTALS: 5 ENTHUSIASTIC ACCEPTANCE (B,D,E,F,K)
1 CAUTIOUS ANALYSIS (C)
3 DEFENSIVE REACTION (A,G,L)
3 ACTIVE RESISTANCE (H,I,J)

When all the individual OSR scores are combined, the possible range of points was 9 - 36.

The Composite OSR Score for each Clinic

The tendency of the data to clump together in some of the OSRs resulted in a crowding together of the results in the final calculation comparisons. This tendency was reinforced by the researcher's earlier observation that clinic directors had a vested interest in rationalizing the process of organizational change. Thus, the clinic directors' subjective memories of changes that occurred

several years back in their organizations might produce a "flattening" effect in the data. The researcher believed that in many cases the clinic directors allowed knowledge gained from hindsight to color their perceptions of the past. As a result, there may have been a tendency on the part of some directors to reduce their estimates of the extent of the organizational shifts that occurred in order to make the entire process of change more rational. In addition, such a tendency would support the self-perception that they as leaders had been able to control the process of organizational change.

Table 15 presents the data and the combined OSR scores. The final composite OSR score for each clinic was arrived at simply by adding up the individual scores each clinic received on each of the nine OSR that were measured in the study. The following table identifies the response of each clinic in the sample to each of the nine OSRs, depicting the category of the response (EA, CA, DR, and AR), and the number of points associated with each category of response (4,3,2, or 1). Clinic data are summarized in rows across the table and the composite OSR for each clinic can be found in the column labeled 'TOTL' on the right of the table. The responses to each individual OSR by all of the twelve clinics in the sample can be located by finding the column headed by the appropriate number (1 - 9),

corresponding to the number of the OSRs as described in the text, and reading down the column.

TABLE 15

COMBINED ORGANIZATIONAL CHANGE SCORE
OF ALL CLINICS INCLUDED IN THIS STUDY

	NINE OSR CATEGORIES									
	CHANGE CATEGORY\POINTS									
CLINIC	1	2	3	4	5	6	7	8	9	TOTL
A	DR\2	DR\2	EA\4	EA\4	AR\1	AR\1	EA\4	CA\3	DR\2	23
B	EA\4	EA\4	AR\1	EA\4	DR\2	EA\4	EA\4	AR\1	EA\4	28
C	EA\4	DR\2	EA\4	AR\1	CA\3	DR\2	EA\4	DR\2	CA\3	25
D	EA\4	AR\1	EA\4	AR\1	EA\4	EA\4	DR\2	CA\3	EA\4	27
E	DR\2	AR\1	CA\3	EA\4	DR\2	AR\1	EA\4	AR\1	EA\4	22
F	EA\4	EA\4	EA\4	AR\1	AR\1	CA\3	EA\4	DR\2	EA\4	27
G	EA\4	EA\4	EA\4	EA\4	EA\4	CA\3	EA\4	DR\2	DR\2	31
H	DR\2	EA\4	EA\4	AR\1	EA\4	AR\1	EA\4	CA\3	AR\1	24
I	AR\1	AR\1	EA\4	DR\2	AR\1	AR\1	EA\4	AR\1	AR\1	16
J	DR\2	CA\3	EA\4	EA\4	EA\4	AR\1	EA\4	DR\2	AR\1	15
K	EA\4	EA\4	EA\4	EA\4	EA\4	DR\2	EA\4	CA\3	EA\4	33
L	CA\3	AR\1	DR\2	AR\1	AR\1	AR\1	DR\2	DR\2	DR\2	15

Table 15 the actual scores of each of the clinics and for reference purposes, groups together each clinic's response to each of the nine OSRs. Table 16 depicts the predicted

placement of the clinics based on the hypothesis tested in this study. The point range for each of the three leadership categories (Independent, Dependent, and Jointly Funded) was established simply by dividing the total range of 27 points (from 9 - 36) into three approximately equal parts.

TABLE 16

PREDICTED PLACEMENT

MOST INDEPENDENT OF THE ENVIRONMENT <----		MOST DEPENDENT ON THE ENVIRONMENT ---->
FOUR CLINICS	FOUR CLINICS	FOUR CLINICS
CLINICS C,D,E, & H)	CLINICS A,I,J, & L	CLINICS B,F,G, & K)
9 - 17 Points	18 - 26 Points	27 - 36 Points

Dividing the point range of 9 - 36 points into three almost equivalent parts to reflect the low, medium, and high categories that the clinics were predicted to fall into, and then comparing the prediction with the actual scores, indicated that only five of the twelve clinics fell within range. The comparison of predicted versus actual scores is presented in the following table.

TABLE 17

PREDICTED SCORE RANGE VERSUS ACTUAL CLINIC SCORE

CLINIC	PREDICTED SCORES	ACTUAL SCORE	WITHIN RANGE (YES OR NO)
A	18 - 26	23	YES
B	27 - 36	28	YES
C	9 - 17	25	NO
D	9 - 17	27	NO
E	9 - 17	22	NO
F	27 - 36	27	YES
G	27 - 36	31	YES
H	9 - 17	24	NO
I	18 - 26	16	NO
J	18 - 26	25	YES
K	27 - 36	33	YES
L	18 - 26	15	NO

Grouping all the clinics in this manner, and then strictly adhering to the range clearly yielded discouraging results. Only six out of the twelve clinics fell within the predicted range. However, breaking the clinics out by leadership style, and then looking at those clinics that are "near misses", i.e., just outside the range, yielded some interesting results. The following table depicts this

information. The shaded areas (shading is represented by a series of XXXXXs) indicate the predicted range for each category of leadership.

TABLE 18

PREDICTED VERSUS ACTUAL CLINIC SCORES
BY LEADERSHIP CATEGORY

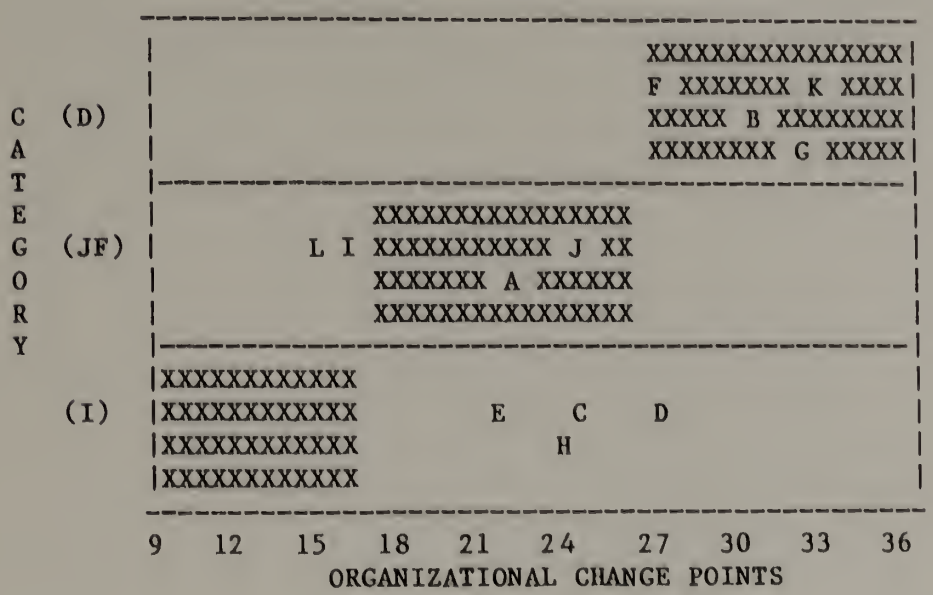


Table 18 illustrates that there were at least two different problems present in the final results. The first is that ten out of the twelve clinics scored within a ten point range (22 - 32), indicating a clustering of the score results. The second is that while the Dependent Leadership category scored at least close to the range, and the Jointly Funded Category scored within the predicted range, the Independent Category is so far from the predicted range that the closest scoring clinic was still thirteen points away

from the edge of the predicted score range.

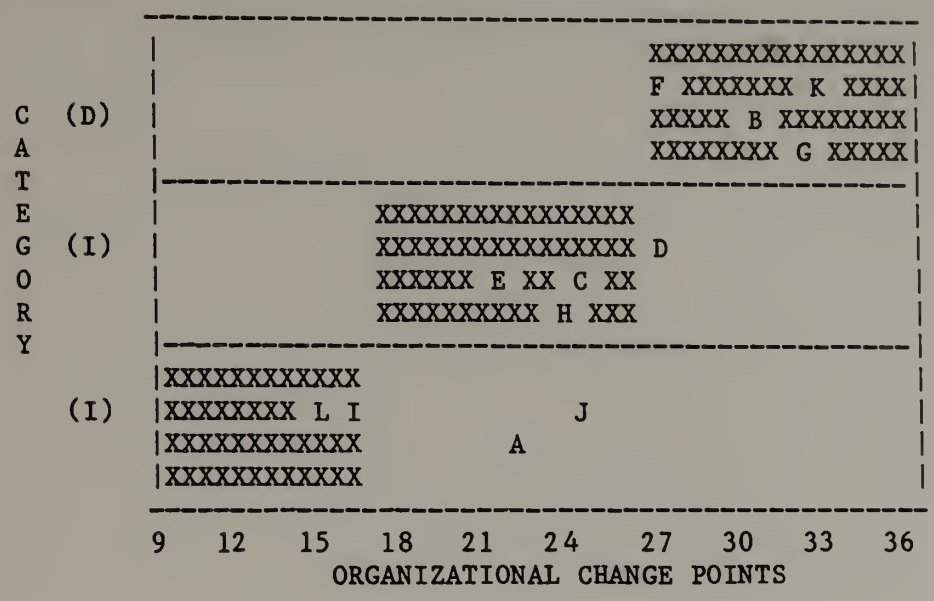
Alternative Definition of the Independent Variable and Implication for Results.

Initially, it was predicted that shared funding between the DMH and a local BOD would result in countervailing forces that would produce an OSR somewhere between Independent and Dependent. However, after calculating the final OSR scores for each clinic, it became apparent that the JF leadership clinics actually exhibited less change (or a lower OSR score) than both the Independent and Dependent leadership clinics.

In fact, when the JF leadership clinics are assigned the most independent leadership category, and DMH leadership clinics are assigned the middle position, with BOD leadership clinics still assigned the most dependent leadership position, a Pearson Product-Moment correlation produces an r-squared of .644 ($p < .002$). This rearrangement of leadership categories is illustrated in Table 19.

TABLE 19

PREDICTED VERSUS ACTUAL CLINIC SCORES
BY LEADERSHIP CATEGORY WHEN JOINTLY FUNDED IS
MADE THE MOST INDEPENDENT LEADERSHIP CATEGORY



Despite the gratifying statistical significance attached to this particular operationalization of Jointly Funded as the most independent of the variables, there is also a solid theoretical, as well as a somewhat less solid empirical basis for presenting the data in this manner.

The conceptual argument for calling the Jointly Funded Leadership category the most Independent is based on the model of resource dependency (Pfeffer & Salancik, 1980). This model states that the availability of alternative sources of critical resources reduces the dependence of the focal organization or individual on any single resource, and

therefore reduces the authority or power of that resource over the focal person or organization (Emerson, 1962; Blau, 1964; Pfeffer & Salancik, 1978).

Applying this argument to the placement of the Jointly Funded Leadership category on the independence/dependence scale, it would follow that a leader who had two different funding sources for her or his salary, would feel a reduced level of dependence on each of the individual funding sources, since each provides only part of a critical resource (the leader's salary). Therefore this situation could create a situation in which the top leadership position would actually be more independent than a DMH civil service position that answers to a single organization.

The empirical basis for calling the jointly funded leadership category the most independent can be found in study conducted by Pfeffer & Salancik (1980). The study looked at the effects of ownership on executive tenure in eighty-four United States corporations. Defining ownership as a critical resource, the researchers found that in manager-owned firms where stock was concentrated in the hands of the firm's managers, executive tenure tended to be independent from the firm's performance. The fact that manager's controlled a critical resource (stocks) meant that they were insulated from the normal negative management consequences of poor firm performance.

The strongest relationship between management tenure and firm performance occurred in firms where stock is externally controlled in the hands of a few individuals who do not manage the firm. In this case, the few individuals who control the stock can and do tend to mobilize quickly in the event of poor firm performance and executive tenure is short.

However, the relationship between executive tenure and firm performance was also very weak in firms where stock is dispersed among many shareholders. They theorize that the reason for this weak relationship is that the dispersal of critical resources among many stockholders reduces the dependency of the executive on any single stockholder, thereby increasing executive independence and protecting the executive from negative tenure consequences resulting from poor firm performance.

This empirical research study provides some precedent for defining the jointly funded leadership category as the most independent since the division of critical resources between two different external sources can be viewed as analogous to the dispersion of stock resulting in reduced stockholder control.

Placing the three leadership categories on a scale from most independent to most dependent where Jointly Funded is the most independent leadership category, DMH Funded is the middle category, and BOD funded is the most Dependent leadership category results in a correlation equation in which leadership category can predict 64% of the variance in OSR (r-squared = .644) with a significance level of less than .002. The strength of that relationship provides a strong argument in support of the leadership dependency model despite the obvious problems emanating from the small and decidedly non-random sample size, the weaknesses in the operationalization of both the independent and dependent variables, and the problems of the respondents subjectivity in answering some of the questions.

Possible reasons for these problems are explored in the "Final Discussion" section of this Chapter.

Final Discussion of Findings

Clearly the results of the study did not support the original hypothesis. There are four major reasons why this may have occurred. First, it may be that the hypothesis itself is in error, and leadership accountability characteristics do not alter organizational response to environmental change. Second, it may be that there were

problems with the operationalization of either or both the independent and dependent variables, producing unreliable results. Third, the impossibility of selecting a random sample, and the need to select clinics with leaders who had been in their positions for a minimum of five years may have resulted in a sample that did not accurately reflect the general experience of the remaining partnership clinics. Finally, the small sample size (I interviewed every clinic director who had been in place since 1976 and who was willing to be interviewed) and its restricted nature may have resulted in a skewed data set.

Setting aside possible limitations of the Leadership Dependency Model itself for the moment, this section will begin by exploring the operationalization of both the independent and dependent variables.

The initial proposal identified two categories of leadership - dependent and independent - that were made operational as DMH (Independent) and BOD (Dependent). However, the field research indicated that there were actually six different leadership categories operating in the partnership clinics included in the sample, and these categories represented various combinations of funding, reporting relationships, and leaders.

In order to make the research more manageable and retain some ability to actually test my model, I decided to combine the six leadership categories into three and then predict the position of the three categories on a scale.

However, looking again at the fact that the twelve clinics had six different leadership categories, there is the distinct possibility that the leadership categories themselves are an organizational adaption or OSR to factors in the organization's environment. Further investigation into the history leading up to the creation of the leadership arrangements in place at the various clinics could yield insight into this model.

The three leadership categories that resulted from combining the original six were Dependent (D) and Independent (I), which were both expected and planned for in the original research proposal; and Jointly Funded, a new category that was not expected. As described above, the introduction of the third leadership category and the change in placement of the Jointly Funded leadership category on the Independent/Dependent continuum significantly altered the results of this study.

Because there exists in the literature a strong theoretical and empirical basis for altering the original placement of the jointly funded leadership category and

placing it at the independent end of the leadership continuum, this alteration was termed the 'alternative hypothesis' and will be explored in depth in the following chapter. While altering the analysis after analyzing the data is an unorthodox procedure, the fact that this study both developed and tested the leadership model at the same time, resulted in a need to evaluate the validity of the variables themselves and whether they provided a fair test for the leadership dependency model.

The implications of these results, including the need for further research, are reviewed in the next chapter.

C H A P T E R V I

IMPLICATIONS AND CONCLUSIONS

The theoretical model that this study was based on was well grounded in the literature and addressed a genuine theoretical gap that existed between what is popularly known as the "macro" perspective of organizational theorists who look at the interaction between organizations and the "micro" perspective represented by organizational behavioralists who tend to focus on human behavior within the organization or group.

The model emerged as an attempt to link these two different perspectives through a model of organizational change that attempted to capture the relationship between environment and the role of the top leadership position in an organization.

Once the model was developed, the next step was to attempt to test it in a field situation. An in-depth case study was initially considered. This was not an unreasonable approach to take given the complexity of the model and the fact that there was no reliable data base to

draw from to create a reasonable sample size.

Many of the problems encountered in completing the research could have been avoided had the empirical research been preceded by an in-depth case study that could have both "fleshed out" the model and provided insights into the operationalization of both the independent and dependent variables. For instance, the after-the-fact discovery of a third leadership category, subsequently labeled Jointly Funded leadership, might have been avoided, and, with planning, the JF category could have been incorporated into the model at an earlier time and introduced as the most independent leadership category right from the beginning.

When the JF category was placed in the most independent position and entered into a simple correlation with the OSR scores, the result was an r-squared equal to .644 ($p < .002$). This would indicate that despite the small sample size, there is a relationship between the leadership categories and OSR worth exploring further.

Implications for the Theory

This study tested a leadership model that hypothesized that the accountability requirements and resource requirements attached to the top leadership position in an organization will be the primary determinant of the kind of

response an organization will select when confronted by environmentally initiated change.

This hypothesis was termed the Leadership Dependency Theory and was grounded in the concepts of organizational theorists who treated entire organizations as a unit of analysis in their theories and empirical studies (Aldrich, 1978; Pfeffer & Salancik, 1979) and examined the interaction of the organization as a whole with its environment.

In attempting to build a theoretical model that depicted an organization's interaction with its environment, Pfeffer & Salancik developed the 'Resource Dependency Theory' (1979). Briefly stated, this model proposed that the dispersion of critical resources in the organization's environment will be a primary determinant of that organization's response to the environment.

The Leadership Dependency Theory applied the concept of the resource dependency model to the top leadership position in an organization. By asking in what way the resource requirements of the top leadership position might alter the leader's perception of the environment and thereby cause her or him to alter the organization's response to the environment, the Leadership Dependency Theory introduced the question of the role of leadership to the original Resource Dependency Theory.

Operationalizing the model to the extent necessary to conduct an empirical test was difficult due to both the complexity of the model itself and the dearth of empirical studies that could have provided a model for the operationalization of some of the variables.

Originally, the concept of leadership dependency was made operational in dichotomous independent variable - Dependent leadership defined as a Board of Director's employed clinic director, and Independent leadership defined as a DMH Civil Service employed leader. The initial data collection revealed a third category, labeled Jointly Funded. My initial response to this third category was to place it in the middle of the Independent/Dependent continuum and predict that clinics with this type of leadership category would produce scores somewhere in the middle of the range.

However, the results of the data analysis indicated that clinics with leadership in the Jointly Funded category actually had scores that fell at the most Independent end of the continuum. Consequently, while the original placement of the Jointly Funded (JF) category in the center of the continuum yielded no significant results (r-squared = .177; $p < .17$), moving the JF category to the Independent end of the continuum, and placing the Independent category (DMH, Civil Service employed leader) in the middle and the

Dependent (Board of Directors employed leader) at the most dependent end of the continuum produced highly significant results (r-squared = .644; $p < .002$).

The question then became one of why the Jointly Funded leadership category, made up of clinics with funding from both DMH and a local Board of Directors for the top leadership(s) position, exhibited responses that were more independent of the environment than clinics with funding solely from one source?

The answer to the question came from reviewing the original concept of resource dependency. The original concept was based upon a resource exchange model that states that an organization or individual has power over another to the extent that that organization or individual controls resources critical to the survival of the other. The more dispersed the critical resources, the less power any single resource source has over the focal organization or individual (Blau, 1964; Pfeffer & Salancik, 1978).

Applying this model to the study, the fact that the resources supporting the Jointly Funded leadership category came from two different sources, reduced the criticality of each individual funding source to the focal individual (in this case the top leadership position) and thereby increased the independence of the JF leadership category.

The placement of the JF leadership category at the independent end of the continuum more closely reflected the resource dependency model than did the original mid-continuum placement. In effect then, the model was further supported by this change, since the original lack of significance was the result of a mistake in the hypothesis that produced the operational version of the independent variable, rather than in the leadership dependency model itself.

Implications for Further Research

Further research could reduce some of the subjectivity in the data by interviewing several people inside the organization and in the focal organizaion's immediate environment. For example, the actual relationship between the clinic and the area office was clearly not captured by the question of the number of meetings held between the two organizations on a monthly basis. An interview with the Area Director could have helped to provide an accurate assessment of the relationship.

In addition, a pilot test preceding a larger study that included a more random sample of organizations' from the same set would eliminate some of the surprises that emerged in this study. For instance, a pilot test would have

revealed the third leadership category (JF) in advance, and allowed for an earlier integration of the JF category into the leadership dependency model.

Also, the need to secure permission from the clinic directors in order to study their organizations eliminated a number of clinics from the sample that might have yielded interesting results, such as more of the Western Massachusetts clinics that were impacted by the Northampton Consent Decree. Those clinics in this category were dramatically impacted by the reduction in size of a major public mental hospital accompanied by the infusion of a large amount of public funds into the community. At the same time, they were a minimum of 80 miles outside of Boston, and thus were used to operating quite independently, with only a minimal amount of direction of the DMH central office. It is unfortunate that I could not secure permission from more of these clinics' directors to allow me to include their clinics in the sample.

A major problem that plagued this study from the start was that the theoretical model that was developed, the leadership dependency model, was a complex and difficult construct to test on what was essentially a shoestring operation. The lack of adequate resources precluded an in depth case study or the piloting of the study testing the variables that were made operational in a number of clinics

prior to the formal study. In addition, the lack of formal endorsement to conduct the study from the Department of Mental Health meant that there was little reason for clinic directors to volunteer their time and crucial information about their clinics to a single graduate student researcher who controlled no critical resources for the clinic or its director.

Implications for Organizational Change

Another set of implications that emerged from this study referred to the concerns of public sector policy makers who attempted to create major changes and initiatives in the public sector through conscious manipulation of the external environment of public and private non-profit service agencies. Whether their environmental initiatives consisted of issuing regulations to enforce a new legislative mandate, dispensing funds, or policing agencies to determine whether regulations were being enforced, policy makers are in the business of manipulating organizational environments in order to use those organizations as tools to bring about social change.

In the context of public sector administration, the issue of organizational responsiveness toward environmental changes has enormous implications. Organizations, like human beings, are born, pass through a life cycle, and can

die. Organizational death is usually the result of a failure to adapt to a changing environment (Kimberly, 1980). Under free-market conditions, an organization that is unable to survive because it has not adapted appropriately to environmental change, would be allowed to die and newer, more successful forms would take its place (Chandler, 62).

However, in the public sector, government support of public services creates an environment where organizations may not be allowed to die, even though they may no longer be responding appropriately to environmental changes (Aldrich, 79). This tendency of government to intervene and prevent organizational death has also spilled over into the private sector, where corporate giants such as Chrysler and Lockheed have been kept alive by government intervention.

In the public sector, and particularly in the area of human service administration, the use of government funds to artificially prolong organizational life long after the organization has outlived its purpose, has resulted in a bureaucratic morass of enormous size and opacity. And those of us who supported and even fought for much of the legislation that has created both the state and federal level human service bureaucracy, cannot help but feel uneasy when we compare the cost of maintaining these huge human service institutions with their effectiveness in addressing the problems they were created to deal with.

From proposition 2 1/2 in Massachusetts, to the budget slashing at the federal level, we are witnessing a backlash that threatens to undo the public service efforts of the past forty years. While inflation and its attendant fiscal austerity was the catalyst that triggered these nation-wide budget cuts, it was public frustration with the inefficiency and ineffectiveness of human service programs that has made them a target of the budget cutbacks. In Massachusetts, the human services system absorbed 85% of the cutbacks associated with 2 1/2.

I do not believe that the American public has grown more callous since the mid-sixties. I do not believe that the budget cuts we are witnessing today reflect public indifference to the needs of the disenfranchised. I believe that the budget cuts reflect the public`s cynicism about the effectiveness of pulbic social service programs that were created to deal with the problems associated with this population.

The budget slashing aimed at the Department of Mental Health in Massachusetts is a good example of public exasperation not with the indigent mental health patient, but with the service delivery system that is supposed to provide services to that patient.

From the perspective of management of mental health outpatient services, this study provides the mental health planner/ administrator with insight into the process or organizational change, and hopefully become a first step toward controlling organizational response to environmental change in order to make it a less wasteful and destructive process.

Final Conclusions

In summary, a number of interesting conclusion did emerge, all of which have implications in a number of areas.

1. It appears that for the sample tested, the top leadership position's financial base of support did have a significant impact on that organization's response to the environment.

2. Contrary to some theories, for this sample, the size of the organization did not have any impact on the results of the study.

3. Contrary to common wisdom, the clinics' distance from the central DMH Office did not correlate with any results.

4. Leaders with Joint funding for their positions tend to be the most able to resist changes originating in the external environment. This is consistent with the Resource Dependency Exchange Theory (Pfeffer & Salancik, 1980).

5. Further research should use this model but it is necessary to obtain far more detailed information about all the variables.

The interaction between a focal organization and its environment and the role of leadership in moderating this interaction is a topic that clearly merits further study. The leadership dependency model offers one way of interpreting this interaction, and the results of this study indicate that the model merits further study and consideration. The operationalization of change variables also requires further refinement through future case studies as well as additional empirical research.

In summary, the trends in the data identified in this study support the leadership dependency model and addresses questions of concern to organizational theorists and professionals in the field of policy analysis and social service administration.

A P P E N D I X 1

PRELIMINARY RESEARCH FOR DISSERTATION

SUMMARY OF CRITICAL DOCUMENTS

A P P E N D I X 1

PRELIMINARY RESEARCH FOR DISSERTATION

1. 9/26/77 Letter to Robert L. Okin, Commissioner, Department of Mental Health; from Jerald Stevens, Secretary, Executive Office of Human Services, Massachusetts.

The letter stated in part that Federal Community Mental Health nters in Massachusetts were caught in a bind between Federal Public Law 94-63 which required that they retain and use all third party income to subsidize and eventually replace federal funding, and Massachusetts law which required that clinics return two-third of medicaid reimbursement they receive from clients to the State's general fund.

He indicated in that letter that he would be willing to allow clinics to retain 100% of their medicaid reimbursement contingent on the Department of Mental Health developing the capacity to monitor and control clinic budgeting and service delivery mechanisms.

The letter alluded to the historic autonomy of the partnership clinics and suggested that new mechanisms might be necessary if the Department of Mental Health were to effectively monitor clinic budgets and services.

2. 10/21/77 Letter from Robert L. Okin to Jerald Stevens.

Okin urged an immediate resolution of the conflict between federal and state law because of a threat by the federal government to stop all federal CMHC funding if Massachusetts continued to require that clinics return two-thirds of the medicaid funds to the State general fund.

He said that DMH would immediately begin to "freeze" DMH civil service positions in clinics as they were vacated (i.e. refuse to refill them) and would "convert" the remainder (meaning that the state would exchange the civil service position for an equivalent amount of contract funds to cover the salary of the person who occupied the position). This would eventually eliminate approximately 1,000 civil service positions, and eliminate the "duplicate billing" problem.

[Researchers Note - The original reason that the state required that two-thirds reimbursement from medicaid be returned to the state general fund was a result of the State's reasoning that they already funded, through civil service positions, mental health services. Therefore, allowing the Clinics to also keep medicaid billings for services provided by these civil service staff was "double billing".]

This data led the researcher to originally include the rate of civil service conversion as an indicator of willingness to change on the part of clinics. The variable was dropped when further research indicated that complications with the civil service employees' union prevented the implementation of conversion except in rare cases.

3. 11/2/77 Memo from Stevens to Okin. In this memo Stevens stated the conditions for allowing clinics to retain 100% medicaid reimbursement. They were:

a. DMH freeze clinic civil service staff positions at current levels.

b. All additional medicaid income be closely monitored, and DMH require that it be applied to the clinic's service area mental health needs.

c. All incremental income be used to offset state expenses for essential services (i.e. services for deinstitutionalized clients).

d. DMH will submit to EOHS detailed descriptions of how it will monitor and control the medicaid generated income and subsequent expenditures.

[Researcher's Note: EOHS clearly feared that clinics would exercise their historic autonomy to use the new medicaid funds now available to them for purposes other than to further development of community based services for institutionalized clients. The fears were valid in the face of the DMH's inability in the past to monitor clinics, and the clinic's previous service priorities - higher functioning individuals in the community.]

4. 11/10/77 Memo from Okin to Stevens: Response to above memo.

Okin indicated that DMH would agree to monitor medicaid income generated by clinics; that additional income would be used to reduce state expenditures; and that state positions

in clinics would be frozen at the current level.

[Researchers comment: Nowhere in this correspondence did Okin or Stevens address any hard data questions about the budget implications of100% reimbursement for either Medicaid or the Department of Mental Health. In addition, the DMH did not specify the methods it would use to actually monitor clinic expenditure of funds. At the conclusion of this exchange, the new 100% medicaid revenue retention ruling went into effect.]

5. Revenue Retention Task Force: Formed in early 1978 by the Department of Mental Health to oversee and monitor the revenue retention monies.

The following data drawn from the 7/18/78 Minutes of the Revenue Retention Task Force.

Membership: Chair, Fernando Duran (from DMH central office); plus 10 other people from DMH central office; also there was a representative of the DMH Area directors, the CMHC executive directors, the Executive Office of Human Services, the Greater Lawrence Mental Health Center, Erich Lindemann MHC, Massachusetts MHC, Massachusetts Association of Mental Health, Massachusetts Hospital Association, and the North Essex Mental Health Center.

This meeting established subcommittees to look at problems of: conversion, State owned MHC, Policy issues, and Budget issues.

A. 9/13/78 Conversion Subcommittee Report, Revenue Retention Task Force.

A major concern in this report was that conversion would shift all partnership clinics onto a pure contracting basis with the state and that they would lose their special protected status. [Researchers note: This was clearly the departments intent, as about this time the Department began to aggressively solicit open bidding on all new contracted for service funds from private non- profits in the community. George Brennan discusses this issue further in the report on his interview.]

B. 9/14/78 Report of the Policy Subcommittee, Revenue Retention Task Force.

This group noted that conversion as described at that time allowed money only for salary, and that the fringes paid by the state (totaling close to 24% at that time) were not being replaced by the State. They recommended that funds to cover benefits also be provided.

C. 9/27/78 Report of the Budget Subcommittee, Revenue Retention Task Force.

There were a number of fiscal recommendations, but a central concern in the report was that they had been unable to identify any agency that had the resources to actually monitor clinic expenditures of third party reimbursement.

6. 11/28/78 Memo to All Commissioners, Regional Service Administrators, Area Directors, Clinic Directors, Presidents and Executive Directors of Mental Health Associations, Area Board Presidents, etc. From Robert L. Okin.

This memo announced an Interim Policy for use of Medicaid Reimbursement money. The policy stated that funds could be used for the following priorities, in priority order:

(1) Fringe benefits and employee taxes for conversion; (2) Upgrading of existing programs to reimburseable standards; (3) Strengthening Aftercare services; and (4) Develop or expand CHINS (Children in Need of Services) Programs, services to abused children, and outreach to the elderly.

[Researcher's Note: Because conversion was blocked by state union activity, the first priority was largely ignored. The second priority was the result of Okin's desire to encourage community services to begin to shift reliance from DMH funds to medicaid funds. In order to do this, many programs had to upgrade both the staffing and the physical location of their programs. The priority on Aftercare reflected the Department's desire to persuade community agencies to begin to provide new services for the deinstitutionalized client (hence aftercare, meaning after hospitalization care). The last priority, children and elderly, was the result of the fact that the DMH provided so few funds to serve this population, and had been under considerable pressure from various interest groups to address this underserved population.] 7. Frayda Osten, Associate Area Director, Greater Lawrence Area, Department of Mental Health. June 8, 1981.

Ms. Osten provided me with a detailed description of the history of the Greater Lawrence Partnership Clinic and its relationship to the area office, as well as its track record in providing services to a chronic population. The interviews with Ms Osten were valuable because they provided me with insights into the history over a ten year period of the interactions between an area office and a partnership clinic. The following is a summary of our conversations.

Like the majority of partnership clinics, the one in Lawrence was originally a child guidance clinic and its creation pre-dated the creation of the local Area Office.

In the late sixties, Mary Baine, the clinic's first director left because she was "fed up" with the DMH, primarily as a result of attempts by the central bureaucracy to enforce accountability standards. Dr. Edward Arman was the next psychiatrist director, and he arrived in the early 70's and left in mid 1976. He had a traditional psychotherapeutically dominated notion of the role of a mental health center and under him the center focused on traditional "fifty minute hours" and provided no other form of service. The clinic had long waiting lists and was resistant to serving the chronic population. For instance, the clinic at that time elected not to pursue a day treatment contract offered by the State DMH.

The Lawrence clinic became a Federal CMHC in the late 1970's. When I asked Osten why the community and the Department of Mental Health had supported the clinic in its CMHC application (given its conservative stance) she said that Bill Laine, a powerful Board president, essentially pushed the clinic into becoming the federal CMHC in the area. [Researchers note: The passivity of the local DMH Area office as exhibited in this example, and the relative power of the partnership clinic, based on its extensive history, was common to most parts of the state.]

Just prior to the award of the CMHC grant, Dr. Gersh Rosenblum, MD, was hired as Director of Clinical Services. He applied for, but did not get the job of Executive Director at the clinic, which went to an out-of-stater, Dr. William Krueger, a Ph.D. psychologist.

Krueger inherited a number of problems, not least of which was a clinical director who had competed with him for his job. Additional problems involved a union organizing effort that was in full swing by the time he arrived, a history of hostility between the DMH Area Office and his new clinic, and a agency that had few administrative and clinical controls in place.

Osten said that in the year and one-half since his arrival he has managed to reorganize the clinic, implement an MIS, and begin to develop residential programming capacity for chronic clients.

She mentioned that the clinic was still plagued by a number of problems peculiar to all Massachusetts clinics such as: the Area Office's attempts to exert greater State control over community based programs; and the conflict between the federal CMHC lead agency mandate versus Okin's resolve to pursue competitive bidding at the local area.

[Researcher's Note: the lead agency mandate was part of the original legislation that resulted in the CMHC's. It stated that each area CMHC would serve as the lead or umbrella agency for all mental health funds in a geographic service area, and would subcontract all services. The intent was to develop a coordinated, non-duplicative mental health service system.]

Osten mentioned that Krueger felt that the clinic should be administering a number of programs that had been awarded to competing agencies, especially to the Greater Lawrence Psychological Center. She said that there was a certain amount of hostility between the clinic and this competitive agency.

7. Dr. William Krueger, Executive Director, Greater Lawrence Mental Health Center, June 23, 1981.

Dr. Krueger echoed most of the problems outlined by Frayda Osten. Naturally enough, he felt that the conflict between the federal CMHC goals and the State competitive bidding focus was unfair to CMHC's and detrimental to establishing an effective area-wide system.

He also indicated that the local area office was not sensitive to administrative overhead costs in non-profit agencies (a concern that I heard echoed many times in the Franklin-Hampshire area also). Krueger addressed the need to increase administrative overhead in order to manage the fiscal responsibilities of an agency that both managed extensive contracts and paid for services through third party reimbursement.

In talking about his role he discussed the difficulty in making major organizational changes when confronted by a union organizing effort on the part of staff, who were suspicious of any kind of administration initiated change.

APPENDIX 2

INTERVIEW PROTOCOL

CLINIC NAME

ADDRESS

EXECUTIVE DIRECTOR/
TENURE IN OFFICE/---
DEGREE

ADMINISTRATIVE DIRECTOR/
TENURE IN OFFICE/ ---
DEGREE

CLINICAL/MEDICAL DIRECTOR/
TENURE IN OFFICE/ ---
DEGREE

NAME AND POSITION OF INTERVIEWEE

PHONE

INITIAL INTERVIEW DATE

SUBSEQUENT INTERVIEW DATE

****

SIZE OF CLINIC AS INDICATED IN FISCAL YEAR 1976 ANNUAL REPORT

A. TOTAL BUDGET SIZE

B. TOTAL NUMBER OF STAFF (FTE)

D. PLEASE INDICATE WHETHER THE TOP MANAGEMENT POSITION IS/WAS CIVIL SERVICE OR BOARD OF DIRECTORS EMPLOYED.

1. CIVIL SERVICE
---

2. BOARD OF DIRECTORS ---

DEPEN: / VBLE	76	77	78	79	80
BUDGE: SIZE :					
: STAFF: SIZE :	:	:	:	:	
NUMBE: OF PROGR: CHRON: CLIEN:	:	:	:	:	
% : ADMIN: OVERH:					
NUMBE: AREA OFFIC: MEETS: PERMO:	:	:	:	:	
% : 3RD PARTY: REIMB:	:	:	:	:	
% : BUDGE: FOR CHRON: CLIEN:	:	:	:	:	
% IN- : SERVI: FOR CHRON: CLIEN:	:	:	:	:	
AVERA:					

E. WHAT IS THE TITLE OF THE TOP MANAGEMENT POSITION IN YOUR CLINIC?

1. EXECUTIVE DIRECTOR _____

2. ADMINISTRATIVE DIRECTOR _____

3. CLINIC DIRECTOR _____

4. OTHER _____

DEPEN: / VBLE :	76	77	78	79	80
BUDGE: SIZE :					
STAFF: SIZE :					
NUMBE: OF PROGR: CHRON: CLIEN:					
% ADMIN: OVERH:					
NUMBE: AREA OFFIC: MEETS: PERMO:					
% 3RD PARTY: REIMB:					
% BUDGE: FOR CHRON: CLIEN:					
% IN- SERVI: FOR CHRON: CLIEN:					

	76	77	78	79	80
% PSYCH: ANLYT: TREAT: MENT :	:	:	:	:	:
MGMNT: INFO : SYSTM:					
STAFF: PROD : REQUI:	:	:	:	:	
CHANG: IN CLIEN: SERVE:					
% BUD: DMH CONTR:					
AVERA: LENGT: OF TREAT:					

H. IF THERE HAS BEEN AN INCREASE/DECREASE/CHANGE IN PROGRAMS OFFERED BY THE CLINIC, PLEASE DESCRIBE THOSE CHANGES:

1.CHANGE IN TYPE OF CLIENT SERVED

_____

_____

_____

2. CHANGE IN PROGRAM STRUCTURE/PHILOSOPHY/TREATMENT MODALITY

_____

_____

_____

I. HOW WOULD YOU DESCRIBE YOUR RELATIONSHIP WITH THE AREA OFFICE? HAS THAT RELATIONSHIP CHANGED SUBSTANTIALLY SINCE 1976?

I. HAVE THERE BEEN ANY CHANGES WITHIN PROGRAMS THAT EXISTED PRIOR TO 1975?

1. INCREASE/DECREASE IN SIZE _____

2. IF YES TO I.1., INDICATE PROGRAM BUDGET CHANGES FROM 1975 - 1980. (IF MORE THAN ONE PROGRAM INDICATED CHANGES, GO TO ATTACHMENT H TO CONTINUE THIS SECTION.)

1975 _____

1976 _____

1977 _____

1978 _____

1979 _____

2. CHANGE IN CLIENTS SERVED _____

---

3. CHANGE IN TREATMENT MODALITIES? _____

A P P E N D I X 3

LETTER TO CLINICS

Lorraine Carulli
305 G Mansfield St.
New Haven, CT 06510
Ph. (203) 865-6611

October 26, 1981

Clinic Director,
ABC Clinic
Small Town, MA

Dear Clinic Director,

I would like to request your assistance in a study of partnership clinics in Massachusetts that I am conducting as part of my doctoral dissertation at the School of Education, University of Massachusetts at Amherst.

The purpose of the study is to examine the relationship between leadership and organizational change in partnership clinics during the period from 1975 - 1980. As a first step in completing my dissertation I need to select ten clinics that had the same person in a leadership position during that five year period of time.

Participation in the study will require that the clinic director spend a maximum of two hours with the researcher, and that another member of the administrative staff be willing to spend a total of three hours helping me to retrieve data.

Because I am attempting to measure organizational change, the data I will be looking for include change in the following areas: total budget size, size of different budget categories, programming and programming goals, and staffing patterns.

While I anticipate that in most cases the data collected will be public information that the agency routinely shares with funders and other sources, the study methodology will still take care to insure that agency confidentiality requirements are strictly adhered to, and written reports will not name the participating agencies.

Because a major goal of the study is to chart both the

magnitude and the type of changes that occurred at each site during the five year period from 75 - 80, each participating clinic will receive a report that summarizes its own progression of changes during that period.

I will telephone your clinic sometime within the next week to determine (1) whether your clinic had the same person in a leadership position during the period under study, and (2) if that is the case, whether or not you are interested in learning more about becoming a study site.

I will be glad to provide references and answer any further questions you may have over the phone. I truly appreciate any help that you can give me in completing my research.

Sincerely,

Lorraine Carulli
Ed.D. Candidate
School of Education,
University of Massachusetts at Amherst.

P.S. Director names and addresses for this mailing were obtained from the DMH central office and reflected their most recent listing. I apologize for any errors due to changes made since the directory was published.

A P P E N D I X 4

ALL PARTNERSHIP CLINICS IN MASSACHUSETTS

LEADERSHIP STATUS
OF ALL PARTNERSHIP CLINICS IN MASSACHUSETTS

ALPHABETICAL BASED ON THE NAME OF THE CLINIC
ACCURATE AS OF 1/1/82
OR DATE NOTED UNDER TELEPHONE NUMBER

1. ATHOL CLINIC (617) 249-3211

John Szivos
Clinic Director
Athol Clinic
1564 Main Street
Athol, MA 01331

* In 69 Gardner/Athol MHC established an outpatient clinic in Athol. In order for Gardner area to receive CMHC $ it needed to acquire Athol and surrounding 6 towns. So 7 town area assigned to them for a temporary 10 year period. Then it would go back to F/H.

* In 71 Gardner awarded to CMHC staffing grant.

* In 73, Gardner State Hospital closed and clinic moved off hospital grounds. Dr. Gibeau became Executive Director.

* In 79 Gibeau left, new director was hired and fired within one year.

2. ATTLEBORO AREA COUNSELING CENTER (617) 226-1660 (11/4/81)

Ms. Mary Ann Powers,
Executive Director
Attleboro Area Counseling Center
219 Park St.
Attleboro, MA 02703

* Present director hired in 1978. Prior to that the clinic had a psychiatrist clinic director (DMH appointed) who resigned, precipitating her hiring.

3. BEAVERBROOK GUIDANCE CENTER (617) 891-0555 11/3/81

Dr. Ralph G. Semon,

* Semon has been DMH clinic director since 1976. In 1976 an administrator was hired, then a second

Clinic Director
Beaverbroook Guidance Center
118 Central Street
Waltham, MA 02154

administrator was hired to replace the first in 1979.

* Not interested in being part of the study.

4. BERKSHIRE MENTAL HEALTH CENTER (413) 499-0412
11/3/81

* Three leadership changes in that five year period.

Mr. Raymond Brien,
Executive Director
Bershire Mental Health Center
Madonna Hall
333 East Street, 4th Floor
Pittsfield, MA 01201

5. BLACKSTONE VALLEY MENTAL HEALTH CENTER/ VALLEY ADULT COUNSELING SERVICE (617) 478-0820
11/3/81

* Deputy Director acted as director from 1976 - 1977.

* Current director is DMH.

Mr. Benjamin Lewis,
Executive Director
Valley Adult Counseling Service
Countryside Drive
Milford, MA 01757

* Currently restructuring to become a CMHC and to achieve JCAH accreditation.

* NO to study.

6. BLACKSTONE VALLEY YOUTH GUIDANCE CENTER (617) 473-6723
11/3/81

* Inc. 1968. Current Director has been with the clinic three years.

Mr. Martin Dobrow
Executive Director
Blackstone Valley Youth Guidance Center
Mill Street
Hopedale, MA 01747

* One director prior to this one.

* Current Director was Area Director in Framingham for DMH.

7. BRIGHTON/ALLSTON MENTAL HEATH CLINIC (617) 277-8107 or 787-1901

* Current Executive Director has been there six years.

Barbara M. Cosgrove,
Executive Director
Brighton/Allston Mental Health Clinic
330 Market St.
Brighton, MA 02135

* Small Center with only 11 or 12 staff.

8. BROCKTON MULTI-SERVICE CENTER (617) 378-7232

Mr. Paul J. Tausek,
Administrator,
Brockton Multi-Service Center
165 Quincy Street

* In 1975 there were only two employees. Currently reorganizing.

* They are now negotiating a new partnership agreement.

9. BROOKLINE MENTAL HEALTH CENTER (617) 277-8107

Ms. Cynthia D. Price,
Executive Director
Brookline Mental Health Center
43 Garrison Road
Brookline, MA 02146

* Executive Director changed in 1976 and again in 1979.

* NO to study.

10. CAMBRIDGE GUIDANCE CENTER (617) 354-2275

Dr. Arne J. Korstvedt,
Clinic Director
Cambridge Guidance Center
5 Sacramento Street
Cambridge, MA 02139

* 1974 current director came to the clinic as chief psychologist.

* Former director became area Director.

* In 1976 present director assumed the role of clinic director.

11. CAPE COD MENTAL HEALTH CENTER (617) 563-2262
11/4/81

Dr. Robert W. Blanchard

Cape Cod Mental Health Center
Thorne Building
P.O. Box 989
County Road
Pocasset, MA 02559

* 14 years clinic director.

* On special leave from 75 to 80.

* Resumed leadership of clinic in 1981.

* DMH civil service position.

12. CENTER FOR HUMAN SERVICES (617) 999-2321

Mr. Warren Davis,
Clinic Director
Center for Human Services
P.O. Box A2097
New Bedford, MA 02740

* Change in leadership in 1977.

14. CENTRAL CITY COMMUNITY CENTER (617) 823-6124

Mr. Chuck Fitzsimmons

* Two changes in leadership during period from 1975 -

Clinic Director
Central City Community Center
19 Cedar Street
Taunton, MA 02780

1980.

15. CHILD GUIDANCE CLINIC
OF SPRINFIELD, INC.
(413) 732-7419

Dr. Michael Green
Clinic Director
Child Guidance Clinic of Springfield
759 Chestnut St.
Springfield, MA 01107

* Dr. Green has been clinical and executive director there for 25 years... Civil Service position.

16. COASTAL COMMUNITY
COUNSELING CENTER (617) 471-0350
479-5603

Dr. Ronald Hersch,
Executive Director
Coastal Community Counseling Center
77 Parking Way
Quincy, MA 02169

* (Same as South Shore) Director left in June of 77; three person triumverate from the board of directors ran the clinic till January 78 when Hersch took the leadership position. He then reorganized the clinic into five separate corporations.

17. COMMUNITY CARE MENTAL
HEALTH CENTER (413) 736-3668

Dr. Miriam I. Leveton
Clinic Director
Community Care Mental Health Center
273 State St.
Springfield, MA 01103

* Same director since 1975.

18. CROSSROADS COMMUNITY
GROWTH CENTER (413) 536-4240

Mr. Robert W. Dranka,
Executive Director
Crossroads Community Growth Center
359 Dwight St.
Holyoke, MA 01040

* Relatively new clinic - late 1970's; strongly sponsored by DMH area office.

19. CUTLER COUNSELING CENTER
17) 769-3120

Dr. Dorothy Uhlig, Ed.D.,
Executive Director
Cutler Counseling Center
10 Cottage St.
Norwood, MA 02062

* Happy to cooperate with study.

20. EAST BOSTON/WINTHROP COUNSELLING CENTER
(617) 567-8760

Mr. Eugene A. Thompson,
Executive Director
North Suffolk Mental Health Association, Inc.
18 Meridian Street
East Boston, MA 02128

21. EASTERN MIDDLESEX MENTAL HEALTH CLINIC (617) 246-2010

* Had an acting Director in 1977.

Mr. Edward J. Domit,
Clinic Director
Eastern Middlesex Mental Health Clinic
7 Lincoln St.
Wakefield, MA 01880

22. FRANKLIN COUNTY MENTAL HEALTH CENTER (413) 774-4313

Mr. Leonard Melnick, (Resigned: 12/82)
Executive Director
Franklin County Mental Health Center
Wells Street
Greenfield, MA 01301

* 1975 - 1978 the clinic had two administrative and one acting administrative director.

* The same DMH Civil Service clinical director was in place from 1965 - 1979.

* Executive Director position created as of January of 1978; first Executive Director lasted from January 78 to June 80.

* Second Executive Director hired in December, 1980.

23. GREATER CAPE ANN HUMAN SERVICES (617) 283-0296
525-3121

Dr. Philip D. Cutter,
Clinic Director
Greater Cape Ann Human Services
298 Washington St.
Gloucester, MA 01930

24. GREATER FALL RIVER MENTAL HEATH CLINIC (617) 676-8187

* Director for five years with the clinic.

Mr. Arthur F. Cassidy,
Clinic Director
101 Rock St.

Fall river, MA 02720

25. GREATER LAWRENCE MENTAL HEALTH CENTER (617) 683-3128

Dr. William Krueger,
Executive Director
Greater Lawrence Mental Health Center
581 Andover St.
Lawrence, MA 01843

* New Executive Director in 1981.

26. HAMDEN DISTRICT MENTAL HEALTH CLINIC a (413) 734-3151

Ralph Holcomb,
Executive Director
Hamden District Mental Health Clinic
367 Pine St.
Springfield, MA 01105

* Executive Director began 9/79.

* Twenty years prior to that a strong DMH director.

27. HAMPSHIRE DAY HOUSE 413) 584-4544

Mr. Patrick Hayes, (Resigned Spring, 1982)
Executive Director
71 Pomeroy Terrace
Hampshire Day House
Northampton, MA 01060

* Executive Director took job in 1980.

28.HERBERT LIPTON COMMUNITY MENTAL HEALTH (617) 343-6966

Dr. Peter T. Adler,
Clinic Director
Herbert Lipton Community
Mental Health Center
Nichols Road
Fitchburg, MA 01420

* Executive Director in position since June of 1980.

* Previous director was there from 1975 - 79.

* Prior to that they had an acting director for 17 months.

29. HOLOYOKE/CHICOPEE MENTAL HEALTH CENTER (413) 534-3361

Mr. John O'Keefe,
Executive Director
Holyoke/Chicopee Mental Health Center
303 Beech Street
Holyoke, MA 01040

* Four director changes since 1975. Current person is first Executive Director.

30. HUMAN RELATIONS
SERVICE OF WELLESLEY, INC. (617) 235-4950

Dr. Robert L. Evans,
Clinic Director
Human Relations Service of Wellsley, Inc.
Wellesley, MA 02181

31. MARLBOROUGH/WESTBOROUGH
COMMUNITY MENTAL CLINIC (617) 481-2100 * 1975 - 1980 two changes in Clinic Director.

Ms. Barbara A. Smith,
Executive Director * Executive Director is not responsible for the clinic.
Marlborough/Westborough Community
Mental Health Clinic
57 Union St.
Marlborough, MA 01752

32. MARTHA'S VINEYARD MENTAL
HEALTH CENTER (617) 693-4460 * Same clinical director for 20 years (DMH).

Ms. Georgia E. Ireland,
Executive Director * Current Executive Director is the first, appointed in 1978.
Martha's Vineyard Mental Health Center
P.O. Box 591
Vineyard Haven, MA 02568

33. MIDDLEBORO-LAKEVILLE COMMUNITY * Three changes in
COUNSELING CENTER (617) 947-6935 leadership from
947-6100 1975 - 1980.

Mr. Menachem Kardan,
Clinic Director
Middleboro-Lakeville Community Counseling
Center
94 South Main St.
Middleboro, MA 02346

34. MYSTIC VALLEY COMPREHENSIVE
COMMUNITY MENTAL HEALTH CENTER (617) 861-0890 * Three changes in leadership from 1975 - 1980.

Donald A. Lund, Ph.D.
Mystic Valley Comprehensive
Community Mental Health Center
186 Bedford St.
Lexington, MA 02173

35. NANTUCKET COUNSELING SERVICE

(617) 228-2689 * Nine years in the Director's position.

Dr. A. Eugene Palchanis,
Clinic Director
Nantucket Counseling Service
Nantucket Cottage Hospital Annex off Vesper Lane
Nantucket, MA 02554

36. NEWTON GUIDANCE CLINIC (617) 969-4925 * Two changes between 1975 - 1980.

Dr. David Paul Mirsky,
Clinic Director
Newton Guidance Clinic
64 Eldredge St.
Newton, MA 02158

37. NORTH ESSEX COMMUNITY MENTAL HEALTH SERVICES (617) 373-1126

Dr. Arthur O'Grady,
Executive Director
North Essex Community Mental Health Services
100 Winter St.
Haverhill, MA 01830

38. NORTH SHORE GUIDANCE CENTER (617) 745-2440 * Director since 1975.

Dr. William C. Madaus,
Clinic Director
North Shore Guidance Center
162 Federal St.
Salem, MA 01970

39. NORTHERN BERKSHIRE COUNSELING CENTER (413) 664-4541

Dr. Franklin S. Dorsky,
Clinic Director
Northern Berkshire Counseling Center
85 Main St., Suite 628
North Adams, MA 02147

40. PLYMOUTH AREA MENTAL HEALTH CENTER (617) 746-7890 * Two and one-half years in the position.

Dr. Dorothy Chase,
Executive Director
131 Court St.
Plymouth, MA 02360

41. SOMERVILLE MENTAL HEALTH

CENTER (617) 623-3278 * Had been the Director only 3 years.

Dr. Kenneth Minkoff,
Clinic Director
Somerville Mental Health Center
63 College Ave.
Somerville, MA 02144

42. SOUTH SHORE MENTAL HEALTH CENTER (617) 471-0350 * Same as Coastal Community Counseling Center.

Dr. Ronald G. Hersch,
Executive Director
South Shore Mental Health Center
77 Parking Way
Quincy, MA 02169

43. TRI-CITY MENTAL HEATH CENTER
617) 321-1060 * Funded as a CMHC in 1979, the first Executive Director was hired at that time.

Mr. Karl Schenker,
Executive Director
Tri-City Mental Health Center
15 Ferry St.
Malden, MA 02148

44. TRINITY MENTAL HEALTH CENTER (617) 879-2250 or 875-6239

Ms. Mary F. Barry,
Executive Director
132 Union Ave.
Framingham, MA 01701

45. WEST-ROS-PARK MENTAL HEALTH CENTER (617) 364-5200 * Began as an agency of Boston State Hospital 14 years ago.

Dr. Harold L. Goldberg,
Clinic Director
26 Central Avenue
Hyde Park, MA 02136

* "Only recently became a DMH partner."

46. WESTFIELD AREA MENTAL HEALTH CLINIC (413) 568-1421

Marguerite Carson,
Clinic Director
Westfield Area Mental Health Clinic
20 Board St.
Westfield, MA 01085

47. WORCESTER YOUTH GUIDANCE CENTER (617) 791-3261

* Thirteen years with current director.

Dr. John F. Scott,
Clinic Director
Worcester Youth Guidance Center
275 Belmont St.
Worcester, MA 01604

* Original partnership clinic.

48. YOUTH GUIDANCE CENTER OF THE GREATER FRAMINGHAM MENTAL HEALTH ASSOCIATON (617) 620-0010 x 41

Ms. Elizabeth L. Funk,
Executive Director
Greater Framingham Mental Health Association, Inc.
88 Lincoln Street
Framingham, MA 01701

A P P E N D I X 5

SUPPLEMENTAL STATISTICAL DATA

SUPPLEMENTAL STATISTICAL DATA SUPPORTING CONCLUSION AND DISCUSSION IN CHAPTERS IV AND V.

DEPENDENT VARIABLE	INDEPENDENT VARIABLE	R-SQUARED*	P <
OSR SCORES	LEAD A	.1774	.17
OSR SCORES	LEAD 2A	.6438	.002
MILES	SIZE	.2570	.09
LEAD A	SIZE	.1810	.165
LEAD 2A	SIZE	.0002	.916
SCORES	SIZE	.0318	.585
SCORES	LEAD	.1159	.279
SCORES	LEAD 2	.4100	.0024
SIZE	STAFF	.6901	.001

* PEARSON PRODUCT-MOMENT CORRELATION

Definitions of Independent and Dependent Variables Used to Produce the Simple Regression Results Depicted Above.

LEAD - The six leadership categories created as a result of reviewing the data from the sample. In order to run the regression each category was assumed to be an ordinal progression on the continuum from most independent to most dependent, with the most independent assigned the number 1, the next most independent assigned the number 2, and so on to number 6. The categories were assigned numbers that reflected the original hypothesis that placed the clinics in the Jointly Funded (JF) leadership category in the middle (scores of 3 and 4) of the independent-dependent continuum.

LEAD 2 -The alternative hypothesis using the six

leadership categories created as a result of reviewing the data from the sample. Each category was assumed to be an ordinal progression from most independent to most dependent. However, in this case the clinics in the Jointly Funded (JF) leadership category were identified as the most independent clinics and were given scores of 1 and 2.

LEAD A - The original hypothesis (with JF assigned the middle score) except that the categories are now reduced to three: Independent (I); Dependent (D); and Jointly Funded (JF). Again, they are treated as an ordinal progression on a scale from most independent (I category), assigned the score of 1; to middle of the scale (JF category), assigned the score of 2; to most dependent (D category), assigned the score of 3.

LEAD 2A -The alternative hypothesis (with JF category assigned the most independent score) with three leadership categories: JF category, labeled most independent and assigned a score of 1; I Category, placed in the middle of the independent/dependent continuum and assigned a score of 2; and the D category, placed at the most dependent end of the continuum with a score of 3.

STAFF - The number of clinic staff (expressed in full-time equivalent positions), including DMH staff in 1976.

SIZE - Clinic budget size in 1976.

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