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ABSTRACT

The purpose of this study was to assess perceptions of the quality of services of consumers of the New York City Division of AIDS Services in restructured and pre-restructured agency settings A total of 447 consumers participated in the study. Data were collected through interviews conducted at DAS field sites around New York City between July and November of 1996, using a 77 item evaluation instrument developed by the researcher and staff from the Mayor's Office on AIDS Policy Coordination On the three quality indicators, satisfaction with services, perception of the effectiveness of the caseworker, and perception of the helpfulness of the caseworker, there were no significant differences between restructured and pre-restructured sites when background factors were controlled. The failure of the restructuring effort was attributed to lack of inclusion of all stakeholders in the planning process

The 1990s can be characterized as the decade in which customer satisfaction became the basis for organizational change. Many business and social service organizations have been adopting some form of Total Quality Management (TQM) or Quality Assurance (QA) programs in attempts to make

their organizations or companies more responsive to customer needs. For example, Berry (1995) wrote that contemporary successful companies made the provision of "great service" their highest priority and provided a strategy for service organizations to become more service oriented through the institution of TQM. Morgan (1997) noted that contemporary organizations are changing and managers are confronting new paradigms and developing new competencies in order to develop organizations that are sensitive to their task environment.

Gaucher and Coffey (1993) indicated that as organizations are increasingly subjected to competitive pressures or, in the case of state agencies, demands for cost-effectiveness, they are being challenged to provide more and higher quality services at reduced cost. One way in which organizations can improve services and lower cost is the implementation of TQM, which requires a customer-focused vision, a capacity for change, and a plan for change. The authors wrote about their experience of implementing TQM at the University of Michigan Medical Center. They found that the initial stages created exhilaration, followed by post-training depression and management resistance and feelings of insecurity. Managers who were used to command and control methods needed to learn how to empower their employees. They reported that in order for TQM to be successful, managers had to change first. They had to be supported, retrained, and included in the change planning process. The process of innovation required continuous feedback. One major problem of implementation was that customers were not being included in the feedback process. Managers had to be made aware of their need to change their behavior relative to the customer. Problems with implementation were: lack of a strategic plan, fuzzy goals, lack of an effective training plan for leaders, accountabilities were unclear, improvement teams were isolated from each other, and few teams were working on issues critical to organizational success. The authors pointed out many pitfalls of the innovation process, including slow results, fear, apathy, ineffective training, and lack of trust. They noted that time must be allocated to training of staff. There will always be resistance, since fear of the unknown will be combined with fear of interests being threatened.

Berman (1995) reported findings from a study of 30 state welfare agency directors who indicated that their agencies had implemented some form of TQM. Berman defined TQM as containing all of the following elements: (1) commitment to customer-driven quality; (2) employee participation in quality improvement; (3) bias toward taking actions based on facts, data, and analysis; (4) commitment to continuous improvement; and (5) developing systemic perspective on service means and ends. Half of the agencies had begun imple-

menting TQM in 1991 or thereafter, suggesting that when the data were collected in 1993, they had less than two years of experience in TQM. Descriptive data indicated that directors indicated that implementation had increased productivity and efficiency, timeliness of service, quality of service, customer satisfaction, amount of service provided customers, and cost reductions. They also reported that commitment to stakeholders had increased along with improvement of decision-making, ability to make improvements despite resource constraints, and stimulating high quality performance. It must be pointed out that department heads indicated that the primary reason for implementing TQM was their own interest in doing so. Therefore, their rosy evaluations of the processes and outcomes must be considered with the understanding that they had an interest in portraying the results in the most positive and least negative terms.

Gaucher and Coffey (1993) suggested that any innovation processes in health care delivery, even those that lead to positive changes, create problems of resistance and organizational instability. Scheid and Greenley (1997) assessed the factors influencing program effectiveness in 29 mental health programs using a sample of 269 mental health providers. Using goal incongruence as an indicator of lack of effectiveness, the authors found that goal incongruence was associated with greater environmental demand, higher complexity of organization, number of work roles, lower professional heterogeneity, lower levels of staff involvement, and lower clarity of expectations. Organizational effectiveness was associated with specialist organizations, that is, those that worked only with chronic patients, number of work roles, lower goal incongruence, and greater staff involvement in decision making. Similar findings were reported for organizational efficiency, except efficiency was additionally influenced by increased external demand. The authors concluded that organizations that offer specialized services and meet the institutional expectations of what constitutes appropriate mental health care view themselves as more effective and efficient than those that do not meet institutional expectations.

As the demand for cost-efficient, effective organizations designed to meet the needs of consumer populations has increased, the impetus for organizational change has been heightened. In Robert Merton's (1957) classic theoretical essay, "Manifest and Latent Functions," he presents the concept of latent functions as those which are neither intended or recognized. A latent function may be the result of unintended consequences of human acts. When humans decide to alter their organizations or institutions, seldom do the results conform to expectations. Sometimes reforms result in failure, such as those outlined in Gouldner's (1954) analysis of a factory administration that

attempted to bureaucratize a mining operation engendering resistance of the workforce to the point of paralyzing operations. Other times, reforms can lead to success while setting off other processes that may create a different set of problems; thus, the Chinese caution, "Be careful what you wish for." The annals of management are filled with successful innovations that resulted in unanticipated consequences. The classical instance of such an innovation was Roethlisberger and Dickson's (1939) study of Westinghouse workers in which the "halo effect" was discovered. The authors found that improving the work environment (e.g., better lighting, frequent breaks) increased worker productivity. However, when they made the work environment worse, productivity still increased, suggesting that worker performance was influenced not only by working conditions, but by the fact that worker output was influenced by the presence of social scientists who were studying them.

When reformers attempt to change the way in which their organizations function, they are usually in for many surprises. In 1995, the Office of the Mayor of New York City decided to restructure its Division of AIDS Services (DAS). As part of the plan, a survey of the user population was conducted in the middle of the restructuring effort, comparing pre-restructured and post-restructured DAS sites on the effectiveness and efficiency of the delivery of services from the perspectives of the consumers. This article reports the results of that consumer survey.

According to the Mayor's Office, the DAS prior to the restructuring was plagued with numerous problems that delayed and interfered with the delivery of services. DAS currently provides public assistance, SSI/SSDI, housing placement, home care, substance abuse/mental health counseling, food stamps, permanency planning, and other social service entitlements to some 18,200 Medicaid eligible men, women, and children living with HIV/AIDS in the five boroughs of New York City (Mayor's Office on AIDS Policy Coordination [OAPC] 1995).

According to the OAPC (1995), consumers had complained that services offered by the DAS were delayed or ineffectively delivered, although the DAS had never collected data on consumer dissatisfaction. Among the criticisms of the OAPC were a lack of a comprehensive and detailed mission statement, duplication of services, inefficient and ineffective service delivery, poor tracking of consumers in the system, lack of articulation of services between the DAS and Income Support AIDS Services, another agency that served the same population, and poorly coordinated emergency housing referral procedures.

Because of the problems evidenced in the DAS, the OAPC developed a restructuring program designed to eliminate waste and duplication of services, provide services that were more efficiently and effectively delivered, and save taxpayer dollars (OAPC 1995). According to the OAPC, in the pre-restruc-

tured system, upon intake, consumers are assigned to a caseworker, who has an average of 41 cases. The caseworker conducts a home visit, assesses service needs, and ensures stabilization. This includes processing an income support case, initiating home care if needed, addressing housing needs, and providing referrals for support services. Once "stabilized" (there is no clear definition) clients call this same worker if there is a breakdown in accessing their benefits or if they have developed a new service need. (p. 5)

In the restructured system, consumers are assigned to an assessment worker for a period up to three months. The assessment worker will have a case load of 20 consumers, and will complete the intake assessment, home visit, service need assessment, placement services, and assure consumer stabilization. Each assessment worker will have a checklist of services to be reviewed for each consumer. Once the checklist is complete, the case is turned over to a case monitoring and reassessment team, which includes five or six caseworkers and an eligibility worker. The team will, in addition to monitoring and reassessment, provide crisis intervention and problem solving services. Each member of the team will have a case load of 30 consumers.

The DAS is mandated to provide homeless consumers emergency housing on the same day that the need for housing is established. In the pre-restructured system, rather than being assigned a temporary residence from the service center, homeless consumers were often required to go to a third location to await placement. In the post-restructured system, homeless consumers await emergency housing at a centralized location that will have extended hours, unlike the sites, which close at 5 p.m. According to the OAPC (1995) plan, this change would result in a better coordinated housing referral system and greater likelihood that consumers would receive same-day placements and would have to make fewer trips between service centers and placement facilities.

Other reforms included streamlining delivery of income support, developing a new computerized tracking system, improving caseworker training, providing consumers with written information about their benefits and entitlements, instituting regular meetings between the DAS and community advocates, and improvement of language services. Also, the reforms were to be evaluated by this researcher.

In New York City in 1995, 71% of the cumulative adult AIDS cases were reported among people of color and 26% were reported among women. Women represent one of the fastest growing categories of people with AIDS in the United States (Stuntzner-Gibson 1991). African American and Hispanic women now constitute 73% of the reported adult female AIDS cases nationwide. The CDC estimates there are 100,000 women infected with the AIDS virus nationwide with 38% of cases reported among female adolescents.

Among children with AIDS, 25% are Hispanic and 53% are African American (CDC 1990).

Statistics reported in a recent issue of Morbidity and Mortality Weekly Report ("Update: Trends in AIDS" 1997) revealed that AIDS deaths in New York City have decreased 30% over the previous two years. Improved medical care and the development of new more potent combination drug therapies have substantially increased the life expectancy of many AIDS patients. However, many AIDS advocates and researchers warn that despite this dramatic decrease in the number of AIDS deaths in New York City in recent years, the number of new infections continues to rise ("AIDS overload" 1997). Statistics reported by the DAS indicate that between 1987 and 1995, the number of cases serviced by the DAS increased from about 1000 to over 17,000. The most dramatic rise in cases was between 1989 and 1993. During that four-year period, cases rose from about 2,500 to over 14,000, an addition of nearly 4,000 cases per year.

Given that the DAS has expanded rapidly over the period of its existence, by 1995, it was ready for an evaluation of the efficiency and effectiveness of its services. It was probably also in need of reform, since organizations often develop patchwork solutions to emerging problems during periods of rapid development. The DAS, according to OAPC (1995), was not organized to effectively deliver services to its consumer population. Therefore, a restructuring plan was developed by the OAPC and implemented.

As noted above, this research was conducted as an evaluation of the restructuring program. This researcher was able to develop several indicators of consumer satisfaction and compare the pre-restructured with the post-restructured sites. The research questions that guide this study are:

1. How do the pre-restructured sites compare with the post-restructured sites on consumer perceptions of caseworker responsiveness?
2. How do the pre-restructured sites compare with the post-restructured sites on consumer perceptions of effectiveness of caseworker in securing services?
3. How do the pre-restructured sites compare with the post-restructured sites on consumer satisfaction?

METHODS

The Sample

The sample consisted of 447 male and female consumers from culturally diverse backgrounds randomly selected from DAS field sites located in the five boroughs of New York City. Consumers selected for participation were receiving services from DAS for a minimum period of three months at the

time of their recruitment. The sample was 58.6% male, 40.7% female, and 0.7% transsexual. Nearly two-thirds (63.7%) were unmarried, 9.8% married, 2.5% living with a domestic partner, and 24.0% were divorced, separated, or widowed. More than half (52.3%) were between the ages of 35 and 44 years, 28.0% were between 25 and 34 years, and 19.6% were 45 years or older. The racial/ethnic makeup of the respondents was 54.4% black (including persons born in Africa, West Indians, and African-Americans), 31.3% Latino, 9.4% white, and 4.9% other (e.g., Pacific Islander, Asian, Native American). More than three-fourths (77.4%) were U.S. born, 19.0% were from Puerto Rico, and 3.4% were from other countries.

The Instrument

The researcher, in preparation for the construction of the survey questionnaire, met with staff members of the Mayor's Office on AIDS Policy Coordination (OAPC) and the DAS. In the meetings, the staff members described what information they wished to be included in the survey. On the basis of the discussions, the researcher developed a 77-item survey divided as follows: demographic information (13 items with probes), information about case work (8 items with probes), DAS sensitivity to consumer needs (4 items), public assistance (2 items), financial assistance (6 items), food stamps (7 items), medicaid (7 items), housing (17 items), home care (10 items), evaluation of DAS services (2 sections with 7 items each), and an open-ended item. Most items were closed response. Some items required probes for greater elaboration. For example, a respondent would be asked a yes or no question, followed by a probe that asked respondents to explain why they responded the way they did. Item 21c was such a case, in which the respondent was asked "Are there services that your DAS case worker got for you that you did not expect to get when you first contacted the agency?" If the respondents answered positively, they were asked to explain by describing the service.

The continual interfacing between the researcher and the staff members of the OAPC and DAS until the survey instrument was refined to everyone's satisfaction provided face validity to the document. Face validity refers to the fact that experts in the field have judged the instrument as adequate to the purpose at hand, namely, the evaluation of the services provided by DAS. In this case, the experts were the staffers at OAPC and DAS.

From the items in the survey, three scales of consumer satisfaction were computed: (a) consumer perceptions of caseworker effectiveness, (b) consumer perceptions of caseworker responsiveness, and (c) consumer self-report of satisfaction with services. Each scale contains five items as follows: a general indicator of effectiveness, responsiveness, and satisfaction; effectiveness, responsiveness, and satisfaction with financial assistance; effectiveness, respon-

siveness, and satisfaction with food stamps; effectiveness, responsiveness, and satisfaction with Medicaid; and effectiveness, responsiveness, and satisfaction with housing services. Because many of the respondents did not use all of the services, there was a substantial loss of data. The Effectiveness and Satisfaction Scales were anchored to 7-point Likert-type response modes from very effective/satisfied to very ineffective/dissatisfied. The Responsiveness Scale items asked the respondents how often they received a helpful response from their caseworker and were anchored to five-point Likert-type response modes as follows: 1 = never, 2 = rarely, 3 = sometimes, 4 = most times, and 5 = every time. The criterion for inclusion in the study was no more than two items on each scale having missing data. Table 1 contains the number of respondents who met the criterion for each scale, summary statistics for each scale, and coefficient alpha (α) reliability estimates.

TABLE 1.
Summary Statistics for Consumer Satisfaction Scales

Scale	*n*	*M*	*SD*	α
Effectiveness	381	24.38	3.76	.81
Responsiveness	365	19.57	3.38	.78
Satisfaction	426	28.68	5.10	.81

Data Collection Procedures

Consumer data for the surveys were collected through interviews conducted at DAS field sites in the five boroughs of New York City. Two waves of consumer interviews were conducted between July and November of 1996. Students from Fordham University and Adelphi University social work training programs were employed as research assistants and conducted the consumer interviews using the evaluation instrument. The research assistants were all persons of color. Their ethnic backgrounds included three Latinos, one Haitian, and one Trinidadian who was originally from India.

Interviews took 30 to 40 minutes to complete. Borough identification codes were used to identify the boroughs where interviews were conducted. Interviewer identification codes were also used to track the number of questionnaires completed at each of the assigned field sites.

The respondents were recruited by the DAS of the City of New York, which sent letters to consumers at seven sites throughout the five boroughs of the city. There were two locations in Manhattan, one in Harlem and the other

in Midtown, one in the South Bronx, two in Brooklyn (Greenwood and Brownsville), one in Queens (Long Island City), and one on Staten Island. In the letter, a telephone number was provided for consumers to call if they wished to participate in the study and receive the stipend. A list of callers was provided to the research team, and volunteers who returned calls were assigned an appointment time to be interviewed at their site.

Prior to the interview, consumers were advised of their rights as participants in scientific research and asked to sign two consent forms, one for the research team, and one for the City of New York. Upon signing of the consent forms, the interview was administered by the research assistant. Consumers who participated in the study were paid a $10 stipend plus $3 carfare reimbursement for their time and cooperation. A common problem was the failure of selected consumers to show for their appointments. In such cases, the research team attempted to recruit a consumer at the site on the spot to fill the vacancy created by the no-show.

RESULTS

Preliminary analyses indicated that the pre-restructured and post-restructured sites provided services for somewhat different populations. The pre-restructured sites tended to serve populations that were older and had more males, drug users, and Latinos than the post-restructured sites ($ps < .05$). However, when examining the relationships between gender, drug use, and Latinos vs. non-Latinos and the three quality indicators, there were no significant differences. Younger consumers tended to perceive their caseworkers as more effective than older consumers ($r = -.12, p < .05$). Therefore, in answering the research questions, the effects of age will be controlled.

Table 2 presents the means, standard deviations, and F-ratios for the pre-restructured and post-restructured sites on the three quality indicators. The data indicate that of the three quality indicators, the only significant difference between pre-restructured sites and post-restructured sites was in consumer satisfaction, with the consumers in pre-restructured sites more satisfied than those in the post-restructured sites.

TABLE 2.
Summary Statistics for Pre-restructured and Post-restructured Sites on Consumer Satisfaction Scales (N=352)

	Pre-restructured		Post-restructured		
Scale	***M***	***SD***	***M***	***SD***	***F***
Effectiveness	24.48	3.94	24.08	3.71	0.96
Responsiveness	19.73	3.86	19.35	2 96	1.08
Satisfaction	29 07	4.97	27 83	5.50	4.85*

*$p < 05$

In order to control for the effects of age, a hierarchical logististic regression was computed in which age was entered into the equation prior to the simultaneous entry of the three quality variables. The results of the analysis are presented in Table 3.

TABLE 3.
Summary of Hierarchical Logistic Regression for Pre-restructured and Post-restructured Sites (N=352)

Variable	B	S.E of B	Wald	R
Step 1				
Age	-0.18	0.07	6.32*	-.09
Step 2				
Age	-0.19	0.07	6.69**	-.10
	-0.01	0.04	0.11	.00
Responsiveness	0.03	0.05	0.32	.00
Satisfaction	-0 05	0.03	3.49	- 06

*$p < .05$; **$p < .01$

The data in Table 3 indicate that when age is controlled, the difference in satisfaction between the two sites drops to nonsignificance. The data suggest that when controlling for site population differences, there are no significant

differences between pre-restructured and post-restructured sites on consumer perceptions of caseworker effectiveness and responsiveness or consumer satisfaction.

Consumers were asked open-ended questions about the performance of their caseworkers. Responses were quite straightforward, and tended to confirm on-site observations by the researcher. When asked to evaluate the effectiveness of their caseworkers, responses ranged from "very effective" to "completely ineffective." Some respondents complained that their caseworker took too long in securing services. Others mentioned specific services, such as food stamps or medical care, that their caseworkers expedited efficiently. Similarly, when asked about the helpfulness of their caseworkers, responses ranged from "resistant" to "extremely helpful," with no clear pattern between pre-restructured and post-restructured sites. When asked to evaluate the DAS services, many suggested that they needed improvement. Some suggested that their caseworkers needed more training. Others were quite satisfied and grateful for the services they received.

What was clear from the survey was that there were no systematic differences between pre-restructured and post-restructured sites on the three quality indicators, despite the fact that the process had supposedly been streamlined, workers case loads had been decreased, and caseworkers were putatively strategically placed at points in the process so that intake could be done more rapidly and effectively.

DISCUSSION

The data from the evaluation suggest that the restructuring of the DAS did not achieve its goal of increasing the satisfaction of its consumers through the development of more efficient procedures. There are several possibilities for these negative findings. First, and most charitably, is the possibility that the evaluation was conducted too early in the restructuring process, not allowing caseworkers to adapt to new procedures and a team approach to service delivery in the DAS. A second possibility is that the changes, although they looked good on paper, did not significantly alter the quality of the delivery of services. This might be because the quality of service delivery was high prior to restructuring, in which case there would have been little or no complaint about services from either consumers or managers. This, however, was not the case, since restructuring was designed to reduce the levels of dissatisfaction and objectively poor service delivery. A more likely explanation for the failure of the restructuring to result in improved service delivery was because the planning was conducted only at the managerial level without sig-

nificant input from staff or consumers. The evaluation of the program was an instance of communicating with the consumers after the fact, a problem encountered by Gaucher and Coffey (1993).

One of the prime principals in organizational change is that those who are to be involved in the change must have a hand in the planning (Bennis 1966, 1969; Berry 1995; Morgan 1997). If they do not, they (a) will not have an operative conception of the change and their place in it, (b) view it as an imposition on their autonomy and prerogatives, and (c) will resent, resist, and attempt to undermine the changes. Modern theories of organizational change and organizational development mandate that all stakeholders must be represented in the negotiations over the change process. Not only does this make them partners in the change, but provides management with much-needed information about how the organization presently operates, suggestions for improvement from those who will be responsible for implementing the change, and insider information about the pitfalls and problems that may not be anticipated by management. The reformers in the managerial strata of the DAS assumed that they knew what would improve service delivery without consulting caseworkers and consumers, suggesting a certain level of hubris and lack of awareness of the politics of change among the managers of DAS. Effective change within an organization cannot be imposed from above; it engenders resistance, factionalism, and conflict.

Rational change must begin with a needs assessment (Bennis 1966). In the case of the DAS, the needs assessment should have been conducted among consumers and staff to find out what occupants of various positions think they need most of all. Consumers and caseworkers need to think about what they need and need to develop priorities. They should also think about how those needs can be met within the organization in an effective and efficient manner. Without this input, management was apparently working from their own theories about how the agency could be improved without grounding them in empirical data. The document produced by OAPC (1995) provides no evidence of a needs assessment, nor of any empirical basis on which the restructuring was based. It does, however, have figures with boxes and arrows that suggest how restructuring will make the process more efficient. The relationship between restructuring and organizational efficiency and effectiveness was an act of faith.

Although organizational change usually begins with initiatives from the top, the impetus for change is usually some form of dysfunctional processes located elsewhere in the system. In the case of the DAS, tremendous growth in the organization over a short period of time and dramatic changes in the demographics of the consumer population necessitated a structural change.

However, since the consumers of the services provided by the DAS tend to come from sectors of the population that are perceived of as self-abusers, drug users, sexual deviants, and ethnic minorities, sometimes referred to as the "disreputable poor" (Matza 1966), the public perception, apparently shared by DAS management, is that they apparently are not entitled to participate in the change process. This perception was also apparently applied to caseworkers. The irony of the failed change effort is that at least the consumers were polled about their satisfaction with the process; the caseworkers were voiceless throughout. This violates one of Berry's (1995) prime tenets that the effective leader must build trust into the system. Gaucher and Coffee (1993) also noted that those in the middle between top management and the customers often feel isolated and cut out of the process even under the best of circumstances.

As in the case of any innovation that fails to produce expected results, this researcher suggests that the DAS conduct a further study to find out what went wrong and why. The critical data source in such a study would be the caseworkers. It is clear from the document from the OAPC (1995) that management thought that it was doing caseworkers a great favor by reducing their caseloads and producing a work environment that would make their efforts more effective and efficient. Such was apparently not the case. Caseworkers need to be queried as to how their old roles differed from their new ones, what changes, if any, they perceived took place, and the consequences of those changes. They need to be surveyed on those organizational factors that interfere with their job performances and how they think the system should be restructured to help them perform more effectively. Finally, prior to any attempts to re-restructure the DAS, a needs assessment should be conducted that includes all stakeholders in the agency (Gaucher & Coffey 1993).

Attempts to change an organization upset ongoing human relationships. If certain sectors of the organization are left out of the innovation process, they will perceive the change to be antithetical to their interests and will attempt to thwart such change. All stakeholders need to be involved in the restructuring of the DAS. Otherwise, such efforts are doomed to failure. As Gaucher and Coffey (1993) have indicated, even the inclusion of all stakeholders does not guarantee success.

REFERENCES

AIDS overload City struggles to handle rising caseloads 1997, 2 February *New York Newsday*

AIDS Rates in Metropolitan Areas in the United States January-December 1996 1997, 18 April *Morbidity and Mortality Weekly Report* 46 (15), 333-335

Bennis, W 1966 *Changing Organizations* New York McGraw-Hill

Bennis, W 1969 *Organization Development: Its Nature, Origins, and Prospects.* Reading, MA Addison-Wesley

Berman, E M 1995 "Implementing TQM in State Welfare Agencies" *Administration in Social Work* 19 (1), 55-72

Berry, L. L. 1995 *On Great Service. A Framework for Action* New York The Free Press

Gaucher, E J , & Coffey, R J. 1993 *Total Quality in Healthcare: From Theory to Practice* San Francisco, CA Jossey-Bass

Gouldner, A W 1954. *Patterns of Industrial Democracy* New York The Free Press

Matza, D. 1966 The Disreputable Poor In Bendix, R & S M. Lipset (Eds), *Class, Status, and Power* (pp. 289-302). New York The Free Press.

Mayor's Office on AIDS Policy Coordination. 1995 *Restructuring the Division of AIDS Services A Plan to Improve Service Delivery to Persons with AIDS* New York City of New York

Merton, R K 1957 *Social Theory and Social Structure.* New York The Free Press.

Morgan, G 1997 *Images of Organization* (2nd ed) Thousand Oaks, CA Sage

Roethlisberger, F J , & W J Dickson 1939 *Management and the Worker* Cambridge, MA Harvard University Press

Scheid, T L , & J.R Greenley 1997 "Evaluations of Organizational Effectiveness in Mental Health Programs" *Journal of Health and Social Behavior* 38 (4), 403-426.

Stuntzner-Gibson, D. 1991 "Women and HIV Disease An Emerging Social Crisis" *Social Work* 36 (1), 22-28.

"Update Trends in AIDS Incidence, Deaths, and Prevalence in the United States 1996" 1997, 28 February *Morbidity and Mortality Weekly Report* 46(8), 165-173.

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