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PRACTICE-BASED RESEARCH AND THE DEVELOPMENT OF A REFLECTIVE ORGANIZATION

by

KEN PEAKE

A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Social Welfare, The City University of New York

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Abstract

Practice-Based Research and the Development of a Reflective Organization

by

Ken Peake

Advisor: Professor Irwin Epstein

This dissertation is a retrospective case study of a practice-based research (PBR) effort within the mental health component of an adolescent health center. The study employs a qualitative, retrospective analysis based primarily on participant observation. It provides an exemplar of PBR as a strategy for building reflective organizational processes - which, in this context, had the goals of building elemental decision-making capacity and enhancing effectiveness.

A group of social worker practitioners used a PBR method to develop an organizational intervention called "the risk project," implemented between 1996 and 1999. Indigenous clinical assessment instruments were developed to help better identify individual adolescent risk behaviors and assess client attitudes toward help, while simultaneously forming the basis for an aggregated information system. The risk project emerged out of a PBR support group composed of practitioners who used an informal and incremental approach to foster research in the agency.

The analysis utilizes Schon's (1983) concept of "reflective practice" to identify the central theoretical assumptions and "guiding metaphors" that were in play during the project's development. It examines where these conflicted with one another or with observed phenomena. Although the cold and impersonal metaphor for the risk project as "research" gradually evolved into one of an "engagement tool," the continued power of the research metaphor suggests that the organizational culture was threatened by clinical innovation. However, the study also indicates that informal, seemingly "idiosyncratic," practices - an element of autonomous practice - may be necessary in the engagement of adolescents, thus shedding new light on practitioner resistance to the standardization implied by evaluation and research methodology. This aspect of social work's practice-research divide has been neglected, both in the literature generally and by PBR advocates The study also suggests that the literature's focus on the impact of published, peer-reviewed, experimental studies on practice has failed to consider the ways in which practitioners and managers might utilize less rigorous, but nonetheless research-derived methods. Instead , a lopsided view of practitioners as research-aversive has resulted. Alternatively, studies conducted "from the ground, up" as this one was, might be used to investigate the utilization of "research-like" approaches in management and direct practice.

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I am grateful to many who helped this project become a completed dissertation. Irwin Epstein, my dissertation supervisor, was also a colleague. He helped develop and sustain the practice based research projects described here. Irwin is a teacher in the best sense of the word and he helped me to see the art involved in dissertation supervision. This project serves as a tribute to the dedication, hard work and creativity of my colleagues at the "Adolescent Center." They are a unique group of practitioners, support staff and managers - who embody professionalism and excellence, often in the face of seemingly impossible odds. I am indebted to Ruth Hoffman who has shouldered a great deal of responsibility, and borne it so well, over the last year as I completed my dissertation work. I am also indebted to Kate Goldman, who worked with me editing and organizing this material and who helped me to continue to laugh at myself despite the apparent seriousness of the endeavor. All deserve my heartfelt thanks.

This work is dedicated to Hope Gilmour Buchan, who was always so enthusiastic at the thought of even the smallest progress, and to her daughter - my wife and partner - Virginia, and to our little Ella.

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Chapter I: Introduction and Overview

1. Introduction

This dissertation is a case study of an organizational intervention and its impact on organizational practices in an adolescent health center, which I call the Adolescent Center (AC). The AC serves an inner-city, largely Latino, African American, and Carribean American, population of young people between the ages of twelve and twenty-one years. The study's research methodology is qualitative and retrospective, and based primarily upon participant-observation.

The intervention, which came to be called "the risk project," was implemented between October 1996 and March 1999. It involved the development and use of clinical assessment instruments by social workers and other mental health professionals. These instruments were indigenous self-assessment questionnaires designed by mental health practitioners for use in the assessment of adolescent clients as a component of the intake process for mental health services. One was a self-administered questionnaire for adolescent clients, intended to assess a range of behaviors, experiences, and attitudes in relation to a number of areas of psychosocial functioning. It was named the AdQuest, and is included in the appendices as Appendix 3. The second instrument was developed for parents of clients, and was called the FamQuest. It included a scale of recent family-events, and a series of questions regarding the parent's views of his or her adolescent client's psychosocial functioning. The FamQuest is included as Appendix 4.

The risk project was developed by a practice-based research (PBR) group, initially composed of four direct practitioners and two managers. This group, called the

MHP research committee, was formed late in 1994. Its goals were to foster PBR activities within the MHP and to generate practitioner research interest.

The goal of this dissertation is to explore the use of PBR as an organizational development strategy for building reflective organizational processes. In this specific instance, it was meant to enhance organizational effectiveness by improving the MHP's program development and clinical decision-making capacities. In so doing, it created the beginnings of a clinical information system.

In my role as the research committee co-chair, which continued until April 1999, and my continued role as the Director of the MHP and Assistant Director for the AC overall, I was a key player in shaping the events described in this narrative. In undertaking this retrospective study of organizational processes, I set about to reflect on events with which I was intimately involved and of which I had a unique perspective by virtue of my managerial position. I was both a participant-observer and subject of this study. Therefore, I take the perhaps unusual, course of narrating this account in the first person - that is using my own voice.

Chapter II, Sensitizing Concepts: Reflective Practice and Practice-Based Research addresses the three central concepts that provide the underpinnings to this dissertation. The first is Schon's (1983) concept of "reflective practice," as conducted by the "reflective practitioner," which provides the foundation for the methodology used in this case study. The second sensitizing concept is the organizational analogue of the reflective practitioner, derived by applying the paradigm to organizational learning theory (Argyris & Schon, 1978, 1992). This provides the theoretical basis for the creation of the research committee and risk project. The last of the three sensitizing concepts, is Practice-Based Research (PBR) (Epstein, 1995, 1996, 1997). Whereas the research committee was the vehicle by which my colleagues and I sought to develop research activities within the

MHP practice, PBR provided the methodology used by the committee to develop research and, as a result, was the foundation for the risk project and other research projects that the committee developed.

Chapter III, Practice Implications of The Changing Health Care Environment is a statement of the organizational practice problems that created the context for this study. It that sets out to define elements in the practice content that support the need for social workers to develop reflective organizational learning strategies. This chapter includes a review of the contemporary literature on the impact of changes in the practice environment and describes the implications of these conditions on practice. One particular imperative that these changes imply is that social work practitioners, at every level of an organization participate in evaluation, practice-research and effects management.

First, I focus on three challenges presented to the social work profession and why they make it imperative that social workers participate in, and develop, reflective organizational practice. These challenges are: (1) changing practitioner role-definitions, (2) the need for research and evaluation methodologies at all levels of organizational practice, and (3) the need to involve direct service practitioners in evaluation and effects management. Second, I discuss the problems regarding the integration of assessment instruments into practice that have been identified in the literature. This is particularly pertinent to this case study, a major focus of which is the development of indigenous and contextual assessment instruments and their introduction into the assessment of adolescents.

Chapter IV, Challenges in Serving Adolescents, is a statement of the problem in terms of clinical practice issues. It makes use of observations from the agency setting, practice wisdom, and the literature, to define elements in the clinical practice content that support the need for social workers to develop reflective organizational learning strategies. Here I describe why reflective organizational strategies can help in addressing adolescent risks. First, I describe the practice setting, the MHP and its auspices. Second, I discuss the issues encountered in serving adolescents within the AC setting and, third, I link this to the literature on adolescent risk. In particular, I draw attention to the competing and contradictory theories that currently guide research on adolescent risks and to the polarized views of adolescents that emerge in the research and clinical literature. These themes are then related to the AC setting, where the view of adolescents as responsible and competent coexists with the view of them as a troubled, high-risk population. I end by showing why adolescent service agencies should include organizational learning and PBR in their development strategies.

Chapter V, Study Design and Methodology, describes the exploratory, descriptive and reflective organizational case study method used in this dissertation. First, I define the theoretical precedents for retrospective organizational case studies of organizational innovations as encompassed in two models, Thomas's (1984) Developmental Research and Utilization (DR&U) model and Reid's (1979) Model Development Dissertation (MDD).

Following the guidelines proposed by Yin (1989), I then describe the unit of study, the research question, the data sources and methodology for analysis. The *unit of study* is the development of the research committee and the risk project, which took the form of exchanges between research committee members and the MHP overall, decisions, and implementation processes that occurred over several years. Because the unit of study consists of complex historical processes, a framework for organization of the narrative and analysis is required. An adaptation of the Differential Program Evaluation Model (DPEM) (Tripodi, Fellin & Epstein, 1979; and also Bielawski & Epstein, 1984) provides this framework, with "phases" of development as follows: The pre-rational, initiation, program contact, program implementation and stabilization phases.

Timelines for the unit of study, that is, the development of the research committee and the risk project, are included. Figures 1a and 1b (pages 88 and 89) illustrate the timelines for this study overall, from 1990 until 1999. Figure 2 (page 90) illustrates the time-lines for the pre-rational phase - that is the formation of the research committee and the growing interest in risk assessment. Figure 3 illustrates the time-lines for the initiation phase of the risk project. Figure 6 illustrates the time-lines for the contact phase, and Figure 8 illustrates the time-lines for the implementation phase.

The *research question* is then described. In a reflective case-study this takes the form of an iteration of the propositions and the implicit and explicit assumptions that were current when the research committee was initiated and during different phases of the risk project.

Next I describe the *data sources,* which included my own observations in the form of a project log, notes of research committee meetings and project design meetings, and other existing agency records.

To derive a *methodology for analysis* I utilize Schon's (1983) concept of "naming and framing," the process by which the reflective practitioner simultaneously defines a problem and the means to address it, and Epstein's (1995) application of the reflective method to a single case study in clinical work. This methodology focuses on identifying the central theoretical assumptions and "guiding metaphors" that were in play during each of the project's phases of development, and examining where they conflict with one another or with observed phenomena. This chapter ends with a discussion of the merits and drawbacks of the participant-observer methodology used in this study.

Chapter VI: The Pre-Rational phase presents the origins of the research committee and precursors to the risk project between 1990 to 1996. Interest in PBR, as a method for enhancing practice, resulted from lingering concerns about improving engagement and client retention. Forays into social work research at the AC during the early nineteen-nineties eventually led to the decision to create the research committee. The committee embraced an "official" model in which its members would foster PBR interest among MHP practitioners overall by serving as non-expert research "mentors." However, the actual approach that evolved was a highly informal and incremental one, in which members became research "advocates," who generally conducted research projects alone. Other developments, such as the increasing formalization of the MHP through the creation of treatment review teams, supervision groups, and new specialized programs, are described. Together these highlighted how idiosyncratic and highly varied were the MHP's assessment and engagement practices, and pointed to the potential benefits of more formalized, standardized and rigorous risk assessment approaches.

Chapter VII, The Initiation Phase describes how, between June 1996 and July 1997 the research committee's concept of a broad "MHP database," evolved into an effort to enhance intake processes through questionnaires designed to assess clients' risk factors and attitudes toward help, family history, parents perspectives on their child's risks, and other related factors. Practice and programmatic concerns about engagement that had long been "in the air," but not formally considered a priority for action, were filtered, refined and "distilled" into a project.

I describe how comparisons of research and practice principles led the research committee members to examine the lack of uniformity in common clinical practices within the MHP. Examples of this included the great diversity in the way confidentiality and client consent to treatment were handled. The use of existing instruments was considered and rejected, and this process helped clarify the risk project's purpose, that is, to enhance the engagement process through the development of indigenous, holistic and comprehensive risk assessment tools. I describe how the committee became clear that these should be designed to invigorate the exchange between client and practitioner - rather than as diagnostic or research tools. The committee concluded that PBR methods could enhance practice and, as a result, the AdQuest evolved from a broad "risk inventory" into an instrument tailored to bring attention to issues to be discussed in the assessment interview.

I end the chapter with an analysis of the phase and the influence of the explicit and implicit assumptions that shaped it. I describe how the committee's cold and impersonal "research" metaphor for the risk project, that is, the "MHP database," had begun to change into a more "practice-friendly" one, that is, "enhancing engagement." I conclude that this augured well for the project, and is evidence that PBR was becoming an effective means to address practitioners' doubts about research.

Chapter VIII, The Program Contact Phase, describes the period between January 1998 and October 1998, when planning began for the introduction of the AdQuest to the entire MHP. The task of contact was framed as one in which practitioners on the committee must reassure and inspire their colleagues by "testing" the AdQuest with their own clients, to address concerns that clients might be adversely affected by the use of instruments.

This assumption led to a Participatory Action Research (PAR) approach which evolved "naturally" from it, and an adolescent focus group methodology was utilized along with instrument "testing" with long-term clients, before the AdQuest was formally introduced to staff. This suggests that adolescents were viewed as a community with a right to self-determination. However, an emphasis on clients resulted in a neglect of exploration of the implications for practitioners. Those outside of the committee did not participate in planning implementation. Despite this oversight, committee members led by "mentoring" their colleagues, for the first time, suggesting their growing competence with PBR.

I then describe how the contact phase led to identification of a need for a family assessment instrument, to be completed by parents, resulting in the FamQuest. Because of concerns that this might lead to a shift in the agency's focus, away from adolescent-centered care, the FamQuest was defined as an adolescent-centered instrument. It would aim to assess how a parent viewed his or her adolescent's risks, coping skills and problems, but would not assess family functioning overall.

This chapter ends with an analysis of the influence of the assumptions that were operating during the phase which was characterized by ambiguity in the way the risk project was defined. In presenting to practitioners outside the committee it was still defined as research-driven, a throwback to the initial image of a "database." The continued power of this metaphor, which distanced practitioners from the project, suggests that the organizational culture was more threatened by clinical innovation than by research. I conclude that, despite the lack of dialogue about the risk project's practice implications and the continued informality of the committee's relationship to the MHP, the committee was becoming comfortable with PBR and its own competency.

Chapter IX, The Implementation Phase, represents the last retrospective component of the dissertation, as implementation led to the realization that significant modifications would need to be made in the research committee's approach if the risk project were to move forward successfully.

First, I describe how the research committee's beginning process of self-assessment, a response to emerging conflicts within the committee, meant that planning for implementation was fragmented due to divisions regarding the risk project's effect on committee resources and time. The first stage of risk project implementation occurred between November 1998 and February 1999, in only one of the three MHP assessment teams. Practitioners were given considerable latitude as to their use of the instruments. The initial implementation experience was a partial success. The AdQuest and FamQuest were both generating valuable clinical information but practitioners were wary of discussing the AdQuest with clients, and rarely did so in the first intake session. Discussions with clients took place in the most problematic cases.

Committee members were encouraged by the clinical information that the instruments were generating but were divided about whether discussion of the AdQuest during the first intake session should be mandated. In planning for the second stage of implementation in all three MHP teams, committee members saw that a more formal approach, though desirable, was not yet practical. The committee's informality imposed limitations on its effectiveness as it was not coordinated with other MHP activities. The second stage of implementation began in May, and by July 1999 it had occurred in all three teams. Now, a period of intensified planning was initiated as the research committee came to grips with the problems of implementing the AdQuest and FamQuest as clinical tools.

I describe the committee's self-examination process, lessons learned, and the recommendations that came from it regarding the risk project and for restructuring the committee. In analyzing the phase I show how the committee was able to reexamine the assumptions inherent in its approach and recognized that its informal, incremental past modus operandi had limited its effectiveness. The recommendations that emerged were for more formalism in the definition of the committee's function in the MHP, in its structure, and in the "contract" with members regarding research participation. In order to formalize the committee structure, I decided to step down as committee co-leader. Reevaluation of how the risk project could be implemented more effectively led to a reconceptualization of it as the first step in a clinical information system that the committee would undertake to develop. A revision of the research committee's mission, goals, structure, and relationship to other MHP subsystems also resulted.

Chapter X Conclusion: Looking to the Future and Program Stabilization sets out to evaluate the risk project and the research committee as to their achievements and condition in June 1999 when the study ended. I discuss the future of each of these efforts, and address the implications that this study has for social work.

Bielawski and Epstein's (1984) conceptualization of the program stabilization phase and the evaluation of program innovations - in terms of effort, efficiency and effectiveness - is used as the framework for the chapter. The risk project is assessed in terms of the goals that the research committee had for it. I describe how, although it had not yet achieved the conditions necessary for stabilization, my colleagues and I concluded that it was a partial success. We decided that it should be continued and strengthened through a more formal research committee effort and the development of a clinical information system.

Next I shift the focus to the research committee and describe the revised mission and plan for it that emerged between June and December 1999. This research committee plan proposed the creation of a formal committee structure and the coordination of committee activities with other MHP activities. It recommended the legitimization of research activity within a practitioner's work scope and performance appraisal process, a project-focused committee structure, and practitioner education.

I then evaluate the research committee's effectiveness in terms of its goals and aspirations. The goal of fostering research participation among MHP practitioners through a "non-expert mentoring model was discarded in June 1999. It had been unsuccessful and had diluted the committee's effectiveness in generating PBR activity. In other areas the committee was more effective. These include the creation of PBR projects, the development of committee members' knowledge, and the enhancement of the MHP practice. I conclude that PBR was an effective vehicle for creating organizational learning processes, despite its being hampered by the committee's structure and model. Effectiveness is also considered in terms of the impact of the committee on my own "viewpoint" as the MHP Director, and the insights it afforded me into the challenges that the setting involves for practitioners engaged in research.

I then focus on the implications for the field that emerge from this study. I discuss the benefits and hazards of formal approaches to fostering practitioner research and under what conditions informal approaches might be best. I describe the insights I gained regarding the function of informal practices and practitioner aversion to standardization in the clinical assessment and engagement process. Garfinkel's (1967) ethnomethodological approach provides a framework for interpreting these phenomena in terms of everyday practice, and for explicating their organizational purpose.

I conclude that this dissertation offers a unique practice-perspective on the research-practice divide. It provides a fresh perspective regarding the functions of informal, everyday practices and the conflict between these functions and evaluation and research methodology. This area of investigation into the practice-research divide has been neglected, both in the literature generally and by PBR practitioners. A fresh perspective is also offered regarding the question of whether practitioners integrate research findings into their practice. I conclude that this debate has focused only on the impact of published studies on practice and has failed to consider the ways in which practitioners and managers might utilize less rigorous, but nonetheless research derived methods. A lopsided view of practitioners as research-aversive has resulted. Studies conducted "from the ground, up" as this one was, might be used to consider the utilization of "research-like" approaches in management and direct practice.

Chapter II Sensitizing Concepts:
Reflective Practice, The Reflective Organization and Practice-Based Research

1. An Overview of the Chapter

This chapter iterates the three concepts that form the theoretical underpinnings for this dissertation study. The first of these, *reflective practice* (Schon, 1983) is described in section two. Reflective practice provided the foundation for the investigative methodology used in this dissertation, as described in Chapter V.

The second sensitizing concept, the *reflective organization*, is described in section three. A theoretical construct, it is an analogue of reflective practice as applied to organizational development. It has not been described in the literature but is derived from the congruence between the reflective practice paradigm and management theories developed from Simon's (1957) principle of bounded rationality, and from organizational learning theory (Argyris & Schon, 1992). From these theories I distill an image of the reflective organization as one which is able to conduct self-inquiry, to be self-critical, and to adapt through innovation.

Section four describes the third sensitizing concept, that of Practice-Based Research (PBR) (Epstein, 1995, 1996, 1996; Epstein, Zilberfein & Snyder, 1997). PBR provided the foundation for the research committee described in this dissertation and for the projects that grew out of the committee. As such, PBR served as the *method*, and the research committee served as the *vehicle*, for the MHP effort to develop organizational learning. Together, as I will describe in Chapter V, reflective practice and PBR also provide a methodology for analysis of the processes described in this dissertation study. I will end this chapter, in section 5, by describing what qualities the PBR approach might suggest be found in a reflective organization.

2. The Reflective Practice Paradigm

In The Reflective Practitioner: How Professionals Think in Action, Schon (1983) describes the "soft" professions, as working with practice problems that are highly complex, difficult to define, characterized by competing and conflicting values, and having unclear ends. Practice problems are not well defined givens but are "constructed from the materials of problematic situations that are puzzling, troubling and uncertain" (Schon, 1983, p.40). In this respect social work is a "soft profession."

According to Schon, practitioners do not theorize first and act later. They bring coherence to uncertain and difficult situations by acting to change them - with "theorizing" being implicit in their actions. This process relies on their use of analogic thinking, i.e., via exemplars and heuristics derived from prior experience in similar situations. While each practice situation and context is unique, practitioners use exemplars almost intuitively to frame a problem - giving coherence, logic and boundary to the unfamiliar. Theory and action are inseparable in a process that Schon calls a "frame experiment" (Schon, 1983, p.63). The frame experiment is the process by which the reflective practitioner defines the problems to be addressed. Through a process of "naming and framing" practitioners first begin to frame the troubling, uncertain problems faced into a workable problem. Schon (1983) says that they face:

> a problematic situation whose reality they must construct. As they frame the problem or situation, they determine the features to which they will attend, the order they will attempt to impose on the situation, and the directions in which they will try to change it. In this process they identify both the ends to be sought and the means to be employed. In the ensuing inquiry, action on the situation is integral with deciding and problem solving is part of the larger experiment of problem setting (p 165).

More recently, the reflective approach was defined in the following way.

> [A] reflective approach acknowledges that, contrary to the idea that formal theorizing precedes action in a linear (from cause to effect) and deductive relationship, theory is typically implicit in a person's actions and may or may not be congruent with the theoretical assumptions the person believes themself (sic) to be acting upon. In Argyris and Schon's terms (1974), there may be a difference between the theory implicit in action ('theory-in-use') and the theoretical assumptions a person might consciously articulate ('espoused theory') (Fook, 1997, p.4).

The reflective practice paradigm work has been widely embraced by the social work field and applied to clinical practice (DeRoos, 1990; Goldstein, 1993; Papell & Skolnik, 1990), administrative practice, (Bernstein & Epstein, 1992) research practice (Epstein, 1995; Fook, 1997) and organizational consulting practice (Epstein, 1995).

3. The Reflective Organization: The Application of the Reflective Practice Paradigm to Human Service Organizations

A central concept of this dissertation is the "reflective organization" as an analog to Donald Schon's (1983) concept of the reflective practitioner. The reflective practice paradigm would appear to be particularly applicable to organizations as it originated in Schon's collaboration with Argyris (Argyris & Schon, 1974; 1978) in studying organizational learning. However, because the concept of the reflective organization has not been discussed in the literature, in this section I will strive to identify what characteristics might lead to an organization being considered "reflective."

Morgan (1986) has used the metaphor of the organization as a "brain" to describe "organizational intelligence" which underlies the idea of organizational learning. He also points out that the idea of organizational intelligence should not be confused with rational decision-making models but is an aspect of organizational learning theory. Organizational learning is concerned with how organizations process information to reflect on their goals and practices to survive, adapt, grow, and improve their effectiveness. Organizational intelligence must be investigated in terms of these types of processes.

Argyris and Schon (1992) discuss the difficulty in defining a paradigm for organizational intelligence as, in contrast to the implications of the brain metaphor, an organization does not possess a mind, neither does it possess a permanent, identifiable repository for organizational knowledge. Moreover, individual minds within an organization (leaders, managers, supervisors and direct service staff) are not permanent organizational components. Nevertheless, some organizations seem to learn, adapt and grow more effectively than others. If, as seems evident, these organizations do develop and retain knowledge and can engage in learning, where in the organizational entity does this learning occur?

Many organizational learning theorists, such as Argyris and Schon (1974, 1978, 1992), Brown and Duguid (1991) and Morgan (1986), locate organizational knowledge in processes that are not always apparent but must be investigated and iterated. Brown and Duguid (1991) define organizational knowledge as "learning-in-working," in which organizational learning occurs through the iteration of "actual and valuable organizational practices rather than "canonical" (or official) organizational practices. From this practice-based viewpoint, they see learning as the bridge between working and innovating.

Argyris and Schon (1974, 1978, 1992) suggest that organizational learning is predicated upon the ability of the organizational actors to examine actual organizational practice and discover and iterate the "theories-in-use" that are driving it. They see organizational learning as occurring when organizational practice is examined in a way that questions assumptions and stated theories about the relationship between desired ends and actual means. The first step in organizational learning involves organizational actors comparing the formal organizational goals, and the official practices used to pursue them, with actual organizational practices. Actual practices might be diverse and numerous and be driven a variety of theories in use, some of which may conflict with one another or with an organization's formal service goals and "official" descriptions of means, i.e., descriptions of service technologies in the form of agency statements about its services, service protocols, treatment standards and procedures, staff training guides, case-record outlines and so on.

Argyris and Schon (1992) suggest that organizations only truly learn when they examine and iterate the interaction between official practices and the various unofficial, actual practices, so that underlying contradictions between them can be addressed. They call this process "double loop learning" (p. 21). To borrow Morgan's metaphor of the brain, double loop learning is analogous to bringing organizational practices into consciousness so that their interactions can be examined, and organizational behaviors adapted as a result.

Many parallels can be found between organizational theory and reflective practice. DeRoos (1990) has drawn attention to parallels between Argyris and Schon's concept of organizational decision making and Simon's (1957) "principle of bounded rationality." Essentially Simon shows that organizational problems are highly complex, amorphous, dynamic, and shaped by values as much as facts. Organizational decision-making is never as rational as might be believed. Managers are rarely able to study a problem thoroughly so as to choose a logical solution before acting. Nonlogical, yet not irrational factors, play a major part in decision-making. Following Simon, Patti (1978) describes organizational decision-making as "satisfycing," that is finding a reasonable, workable solution from among viable alternatives. Decision-making involves balancing competing values and constraints and choosing a "good-enough" option from those that are available.

To summarize, Schon's (1983) definition of reflective practice as a "loose" process with unclear ends and means, and outcomes determined by ambiguous facts and values is consistent with the way many organizational theorists view management practice (Austin, 1989; Brown & Duguid, 1991; Gummer, 1984; Landau & Stout, 1979; Patti, 1978).

What qualities might characterize a reflective organization? The most essential one would appear to be the ability to innovate. However, innovation, in the sense of organizational learning, means the ability to examine the effectiveness of organizational practices, learn from this process and adapt. Morgan (1989) characterizes the challenge of innovation in the following way:

> [I]nnovative organizations must be designed as learning systems that place primary emphasis on being open to inquiry and self-criticism . . . The challenge to design organizations that can innovate is thus really the challenge to design organizations that can self-organize. For unless an organization is able to change itself to accommodate the ideas it produces and values, it is likely to block its own innovations (p.105).

Other characteristics of the reflective organization might be predicated on the challenges that are integral to social service technology. Glisson (1981) has described social welfare service delivery as "intensive" because it involves the unpredictable, "uncontrollable," raw material of people. Even in the best of times, social problems are extremely difficult to define and never have simple, linear solutions. As I describe in the next chapter, in the nineteen-nineties a harsh political and fiscal climate has resulted in social work practitioners having to engage in a wide range of activities that might once have been considered managerial (Blumenfield, 1995; Carpenter & Platt, 1997; Dinerman, 1997; Meenaghan 1995; 1997; Woodrow & Ginsberg, 1997). These factors combined mean that today all social work practitioners - clinicians and managers - must develop strategies for learning in action in an environment in which there is little room or time for reflection (Reid 1997b).

What type of organizational structure is best suited to encourage the development of well-rounded practitioners and to ensure that managers and practitioners engage in learning in action? Morgan (1989) suggests that “bureaucratized” organizations are at a disadvantage. Though hierarchical and bureaucratic structures provide “an effective means for controlling situations that are fairly certain . . . in uncertain situations

[they] can encounter information and decision overload" (p. 82). Furthermore, where situations are uncontrollable and uncertain, more "organic," less-programmed and preplanned organizational styles with more "flexible and ad hoc" (p. 82) approaches are more effective. Bureaucratization is contrary to organizational learning because it leads to an organization's learning needs and capacities being defined by the needs and limits of individual players in specific, narrowly defined, organizational roles. By definition, the reflective social welfare organization is one in which organizational evaluation and development is not defined as a "function" that belongs solely to managers. Rather, it is one in which managers aspire to involve all organizational actors in the process of organizational self evaluation and innovation. Key qualities in such an organization would be flexibility in practitioners' role definitions and in service design, and practitioner participation in innovation.

Another quality of the reflective organization would be that organizational players would seek to enhance organizational effectiveness through an iteration of actual organizational practices and theories-in-use so that comparisons might be drawn between these and canonical goals and practices. What forms might this process take? One form might be practitioner engagement in the development of learning exchanges between organizational subsystems, a conception of the "organization as the client." Some have suggested that social workers are well suited to this type of systemic intervention (Davies & Walsh, 1996; Woodrow & Ginsberg, 1997; Globerman, 1999).

Another form of reflective organizational practice might be the involvement of practitioners in the rigorous evaluation of organizational activities in terms of services and service delivery as compared to the organizational mission, client needs, or the organizational environment. Yet another might be encouraged through practitioner participation in the development of professional practice competencies that are defined in the context of the full scope of the agency's activities. This might be done by comparing the formal expectations that the organization has of its practitioners with the actual demands that the service and practice environment makes on them.

Another quality of the reflective organization might be the routine use of rigorous and standard information in decision-making in management, in service development and design and in practice. As I will discuss in Chapter III, some social work researchers have long argued that practitioners should be more concerned with the effectiveness of programs and interventions (Hudson, 1982; Kirk, Osmalov & Fischer, 1976; Lindsay & Kirk, 1992; Penka & Kirk, 1991) though this perspective is controversial for practitioners and has resulted in a "tense dichotomy" (Sidell, Barnhart, Bowman, Fitzpatrick, Fulk, Hallock, & Metoff, 1996, p. 100) between research and practice.

The PBR approach that I describe in the next section, utilizes research principles to enhance practice, through a number of methods appropriate for service settings. These can include the study of existing data, the development of instrumentation tailored to practice, the rigorous identification, articulation and examination of practice problems and practice principles, and other methods by which organizational practices are articulated and evaluated. As I describe in this study, the development of a PBR group among social workers was intended to operationalize this process of learning-in-action in a wide array of activities. The risk project, which originated in the work of this research advisory committee, was an attempt to approach the issue of the fit between clients' needs and agency practices.

4. Practice-Based Research

PBR, (Epstein, 1995, 1996, 1996, Epstein et al., 1997) offers one model for bridging the research practice dichotomy. Recently, Epstein (in press) defined PBR as:

> [T]he use of research-inspired principles, designs and information gathering techniques within existing forms of practice to answer questions that emerge from practice in ways that inform practice (p.4).

He describes PBR's essential attributes as: naturalistic, heuristic and/or reflective; inductive (with key ideas derived from practice wisdom); non-experimental or quasi-experimental, and; as seeking descriptive or correlation knowledge.

Epstein (in press) draws distinctions between PBR and Research-Based Practice (RBP). He defines RBP as:

> The use of research-based concepts, theories, designs and data-gathering instruments to structure practice so that hypotheses concerning cause-effect relationships between social work interventions and outcomes may be rigorously tested (p. 3).

While both RBP and PBR have grown out of the efforts of social work educators and researchers to integrate research methodologies and findings into practice, to enhance the knowledge-base and improve the effectiveness and efficiency of social work, they differ significantly in their aspirations.

RBP aspires to the search for social work efficacy, to determine what works and what does not work in social work practice. It promotes an "ideal" that practice should be driven by research, and that efficacy of interventions should be demonstrated before they are selected for application in practice (Bloome, Fischer & Orme, 1995; Blythe, Tripodi & Briar, 1994; Fischer & Corcoran, 1994, Gordon, 1984).

This approach is exemplified in what has variously been called the "empirical practice movement" (Fischer 1993; Reid, 1994) and the "scientific practice movement" (Meyer, 1996).

RBP emphasizes an approach that aspires to the "gold standard" (Epstein, 1997) of academic research principles. It is deductive, in that it starts with a theoretically-driven premise. It seeks knowledge that is causal, through research that approximates experimental, randomized control group methods as closely as possible. It is prospective and it relies on standardized, quantitative instruments. Although its practitioners promote collaborative models, research principles outweigh practice principles in the design and implementation of studies.

In contrast to research based practice, PBR is inductive. Though it can be retrospective or prospective, qualitative or quantitative, it relies on instrumentation tailored to practice rather than using externally standardized research measures. Epstein defines PBR as collaborative, with practice considerations outweighing research considerations. Because PBR aspires to enhance practice, its starting point is not social science theory but practice wisdom, i.e., "currently accepted social work practice principles or organizationally embedded program theories" (Epstein, in press, p.4) and its research questions are derived from practice and service delivery problems. The research committee was the vehicle within the MHP for the development of PBR projects, that included the risk project. Epstein, a main proponent of PBR, was the consultant to the committee. However, the selection of PBR as the approach most suitable to the needs of the fast-paced, busy practice environment of the MHP program evolved "naturally," before he was made available to the committee, as I will describe in detail in Chapter VI.

5. Conclusion: Practice-Based Research as a Strategy for Building Reflective Organizational Processes

Although not originally presented as such, the following principles of the PBR model made it an ideal organizational development strategy. (1) PBR does not treat practice and research as highly separate bodies of knowledge but as related fields that can enhance one another. (2) PBR clearly articulates the differences between research and practice agendas and methods - it identifies and builds on commonalties and parallels between the two fields. (3) PBR emphasizes that practice principles and clinical relevance take the lead when there is conflict between practice and research. (4) PBR methods are relatively unobtrusive because practice issues and practitioners drive the research process. (5) In PBR the common complaint that research findings rarely inform practice is significantly reduced because of a relatively instantaneous and continuous feedback loop from findings back to practice.

A PBR approach offers many other potentials for staff development. It creates wider opportunities for direct service staff to develop research skills by "doing" as compared with other approaches to research. By engaging in PBR, practitioners learn to more clearly conceptualize and define their work, which in turn enriches the clinical practice, which is one of its goals.

PBR shares the reflective practice principle of "relevance" over "rigor" when the two are in conflict. Both emphasize that the practice context defines and shapes the investigatory process. The AC's organizational culture valued professional excellence and autonomy, while clinical practice principles and program development principles drive the organizational endeavor. PBR was thought to be particularly fitting to this setting because it actively engages practitioners in examining organizational processes and ensures authenticity in the investigation. Because PBR chooses practice wisdom as its starting point - both in terms of practice principles and organizationally embedded program theories - it can provide a vehicle for the iteration of these theories and principles so as to allow them to be compared with on another and with the official theories that formally guide agency practices.

In this study, PBR was used as both a strategy and a method for creating intra-organizational exchanges to offer insight into organizational practice and opportunities for enhancing effectiveness. More specifically, the risk project was an intervention designed to create information for double-loop learning by identifying implicit theories-in-use and other organizational factors that helped or hindered movement toward the MHP's stated goals.

Chapter III. A Statement of the Problem: Practice Implications of the Changing Health

1. An Overview of the Chapter

In this chapter and the next I address the question: Why should managers and direct service practitioners work together to develop and implement practical models for organizational learning? The answer to this question can be understood in terms of two, somewhat separate, sets of problems that converged in the organizational setting at the heart of this project. My aim in this chapter is to address the first of these - the imperatives for organizational learning caused by the turbulent and evolving environment within which much social work practice is currently being conducted. In the next chapter I will address a separate set of problems that suggests how organizational learning strategies and PBR can be useful to social workers who work with adolescents. These are the challenges to practice and service design created by adolescent risk factors and service utilization. However, in this chapter I will focus specifically on the reorganization currently shaping the health care environment, the setting for much contemporary social work practice, and the issues this reorganization raises for practitioners and managers.

Section two describes how conditions in the contemporary practice environment now make it essential that social workers develop organizational learning strategies. In particular, I describe the need to bridge the too-often, separately conceptualized "worlds" of direct practice, management practice, research and evaluation practice. To achieve this, I locate the imperative for social work models of reflective practice in three challenges currently facing practitioners and managers.

The first of these challenges is related to the changing roles of direct service practitioners who, at the end of the twentieth century, must participate in a broader spectrum of organizational activities than ever. These include accountability initiatives, quality assurance, treatment and service evaluation and/ or justification, and program development and coordination. The result is that individual practitioners must embody their program and professional in their practice. The second challenge is that of integrating research methodologies into practice so as better to address contemporary practice conditions. Here, I discuss the historical polarization of research and practice, that plays a large part in shaping this challenge. The third challenge is the traditional "resistance" of direct practitioners to effects management, i.e., the attempt of managers to evaluate the effectiveness of services. In particular, I focus on explanations for this resistance that have focused on the role of conflicts and dilemmas created by the often dissimilar needs of different levels of the agency structure. One result has been that practitioners may feel scrutinized and/or exposed by management-led efforts to evaluate services. Together these factors suggest that practitioners and managers in social agencies must develop collaborative learning partnerships.

In section three I review and discuss the literature on the development of assessment instruments and their introduction into interpersonal social work practice. Although this discussion relates to the three discourses described in the previous section, particularly to research-practice integration and effects management, it was deserving of a distinct section because the development of two assessment instruments plays a major part in this case study. In section four I conclude this chapter by summarizing how all of these issues combine to support the development of models of reflective organizational practice.

2. The Contemporary Practice Environment: The Obligation to Involve Practitioners, Managers and Researchers in Reflective Organizational Processes

For better or worse, the rapidly evolving environment of fiscal constraint, managed care, shrinking resources and political ill-will toward traditional social work programs, is shaping both management and direct service practice (Almgren, 1998; Blumenfield, 1995; Carpenter & Platt, 1997; Dinerman, 1997; Globerman & Bogo, 1995; Globerman, 1999; Levitt, Beckerman & Johnson, 1999; Segal, 1999; Watt & Kalmen, 1998; Woodrow & Ginsberg, 1997).

In many settings where social workers practice - particularly in health and mental health care - social work managers must not only do more with less but must justify services and staffing in terms of the institutional "bottom line." They must be able to build capacity while facing reduced resources and increased competition for new funding streams. Good decisions about resource use, and the ability to show positive client outcomes, are critical to the social work profession's survival and growth in both social welfare organizations and host settings (Christ, 1996; Jansson & Segal, 1999; Martin & Kettner, 1997; Simmons, 1986).

Trends in the organization and financing of health care, such as managed care and the "corporatization" currently affecting many health care settings, bring an increased demand for justification of services (Dinerman, 1997). As a result, the pressures of accountability are increasingly felt at every level of practice. Consequently, a major challenge now faced by the social work profession is to integrate evaluative methodologies into most aspects of organizational practice.

The nature of what we are accountable for is also changing. Though compliance with broad regulatory and funding imperatives remains important, the focus is shifting and broadening due to pressure to justify all service costs. Managers must demonstrate that services produce effective outcomes and are highly efficient. "Outcome," however, is as much defined in terms of reducing the institutional "bottom line" of cost as in client benefits. Overall, the emphasis of accountability is changing from compliance with broad legal and funding mandates to performance measurement, cost containment, and consumer satisfaction (Marin & Kettner, 1997).

Paradoxically, at a time when social workers are being held more accountable than ever, more must be done with less. As health care organizations cut costs, social work management and programmatic infrastructures are sometimes targets for reduction, resulting in fewer supervisory and support staff. Both practitioners and managers must stretch resources while simultaneously developing efforts to show effectiveness (Marin & Kettner, 1997). Effective and relevant accountability mechanisms are strongest when practitioners, and other stakeholders, are involved in both their design and operations (Bernstein,1988; Preskill & Caracelli, 1997; Savaya & Spiro, 1997). To strengthen services, ensure their survival, and position social work to meet future demands, managers must find ways to involve direct practitioners in most aspects of the overall organizational endeavor.

As a result, both management practitioners and direct service practitioners face huge challenges. The former group must develop ways to increase practitioner participation in organizational processes that were traditionally considered purely management functions. For practitioners, there is a concomitant challenge. In "flatter" departments direct practitioners have to participate in reporting, and accountability systems. They must contribute to the management of the practice environment by participating in efforts to demonstrate how their services benefit the institutions within which they practice (Carpenter & Platt, 1997; Dinerman, 1997; Segal, 1999; Woodrow & Ginsberg, 1997). Siporin (1992) has said that difficult economic times for social work requires innovation and flexibility. Meenaghan (1998) recently summarized the challenge to direct practitioners in one succinct phrase, saying that contemporary social work practitioners must become "program actors in a policy environment."

In this new environment, three highly interrelated challenges can be identified. They are: (1) practitioners must adjust to new constraints, to new demands and to new practice dilemmas and to the greatly expanded, yet still fluid, role-definitions, (2) service organizations must adapt research and evaluation methodologies for use by all levels of organizational practice to enhance accountability efforts, and (3) managers must find ways to partner with direct service practitioners in initiatives that improve efficiency and incorporate effects measurement into all aspects of practice.

A First Challenge: Practitioners' Changing Roles

Though many authors cited earlier believe that social workers are well prepared to deal with these sweeping changes in the practice environment, a significant portion has indicted that direct practitioners are experiencing severe strains to their professional identities as result. (Carpenter & Platt, 1997; Chernus, 1999; Davis & Walsh, 1996; Galambos, 1999; Gibelman & Whiting, 1999; Globerman, Watt & Kallman, 1998). Several effects have been documented in the literature. Strom and Gingerich (1993) point out that these effects - positive and negative - are complex, interrelated, and have multiple causes. They say that:

> The forces influencing service delivery are numerous and varied. They do not lend themselves to linear cause-and-effect explanations. Rather these issues, individually and in concert with others, help to shape the auspices under which services are provided, who may deliver and who may receive them and the conditions under which services may occur (Strom and Gingerich 1993, 79).

Strom and Gingerich (1993), and others (Montenko et al., 1995; Reid, 1997b; Siporin, 1992), note that higher productivity standards mean that practitioners are working harder, but have much less time and opportunity for reflection than was the case a decade ago. In mental health settings, in both the for-profit and nonprofit sectors, the pressure to reduce service costs has led to a tendency for clinical judgements to be replaced by treatment time limits (Borenstein, 1990). With managed care, the prescription of set lengths of service for different problem diagnoses may result in clients being "under-treated." This is one result of the "limitations of placing complex problems, often with systematic causes, [forced] into narrow individual diagnoses" (Strom and Gingerich 1993, p. 80).

Social workers are often caught between competing priorities - the needs of the individual client versus service limitations due to financial auspices and institutional pressures. Such conditions limit professional autonomy, clinical judgement, and the ability of practitioners to respond to the "whole person" in the context of the social environment. These limits conflict with core service values of the profession. With reduced supervisory staff social work managers must develop innovative ways to provide support to direct service practitioners and create appropriate vehicles to address these practice dilemmas.

Strains between practitioners and managers regarding issues of professional autonomy versus organizational control have long been present in social service organizations (Grasso & Epstein,1987; Patti, 1983). Paradoxically, at a time when managers must encourage and support greater practitioner involvement in traditional "management functions," practice conditions may increase the strains between them.

A Second Challenge: Adapting Research Methodologies to Address Contemporary Practice Conditions

In principle, it is possible that the climate of increased accountability will encourage the development of practitioner involvement in research activities. However, the contradictory demands on practitioners' priorities and time, and the existence of fewer supports, are not conducive to reflection (Reid, 1997b). Many of the writers I have cited note that social workers increasingly must struggle to address conflicts between serving clients and other demands.

Involving practitioners in the development and design of practice-relevant research and evaluation is not an easy task. Longstanding fissures exist between these areas of practice (Epstein, 1995; Fanshel, 1980; Rosen & Mutschler, 1982). This has been referred to as a "continuing crisis" between social work practice and research (Lindsay & Kirk, 1992, p. 370). Though considerable disagreement exists about the causes of this situation (Blythe & Briar, 1985; Davis, 1986; Epstein, 1994, 1995; Gorey, 1994; Penka & Kirk, 1991; Kirk, Osmalov & Fischer, 1976; Schwartz & Breunlin, 1983), the term "crisis" symbolizes the longstanding dichotomization of practice and research. Practitioners have too-long seemed wary of, or disinterested in, research (Adler, Alfs, Greeman, Manske, McClellan, O'Brien, & Quam, 1993; Epstein, 1996; Gantt, Pinsky, Rock & Rosenberg, 1990; Sidell et al., 1996; Subramian, Seigel & Garcia, 1994; Pruett, Shea, Zimmerman & Parish, 1991; Weiss, 1974; Weinbach, 1985).

In comparison to direct service practitioners, managers have tended to accept research and evaluation methods. Because these methods can provide useful information to managers, the benefits of evaluation are often more evident to them than they are to practitioners. As a result, managers' comfort-levels with accountability and research methodologies are far higher those than among practitioners (Weinbach, 1985). Practitioners have good reasons to be distrustful of research and evaluation because, too often, researchers have focused on proving or disproving the question, "does practice work?" rather than on helping practitioners with practice problems (Epstein, 1995). Managers, and also academic researchers, might bear some responsibility for the lack of practitioner involvement in research, accountability and evaluation, as these practices are often imposed from the top down.

One model that has been proposed to involve practitioners in research is the collaboration between practice setting and academia (Pruett at al., 1994; Young, 1986; Subramian et al., 1994; Turnbull, Saltz & Gwyther, 1988). This model had been both explicitly and implicitly advocated by proponents of RBP (Blythe, Tripodi & Briar, 1994; Ivanoff, Blythe & Briar, 1987, 1985; Penka & Kirk, 1991; Fischer, 1981), described in Chapter II. However, those who propose this model do not provide a method for addressing the differing agendas and methodologies that agency and academia each bring to the table. RBP proponents tend to view these differences in agenda as resulting from practitioner resistance and fear of scientific methods. Such deficiencies are viewed as obstacles to be overcome. As a result, RBP proponents do not offer research strategies and methods that are particularly suited to practice problems.

One report of a collaborative effort between agency and academia that has been referred to by many others who propose such collaborations (Adler et al., 1993 Subramian et al., 1994; Pruett et al., 1991) is Young's (1986) prescriptive case study of an agency - social work school collaboration. Young cautions that researchers are "guests" in "host settings," an unfortunate, if accurate, metaphor. She identifies core questions for practitioners and researchers. Practitioners are advised to focus on whether research will interfere with services, how patients will react to recruitment, on legal and community concerns, and on fiscal benefits. Researchers should focus on their levels of access to patients and records, on staff's willingness to fill out research forms, and the stability of the setting. While researchers are advised to provide in-service training *to* staff, the possibility that practitioners might have a contribution that could better shape research questions and methods is ignored.

Strom and Gingerich identify another core problem with the academic-practice partnership model as its failure to meet current market conditions, that call for "practical evaluation . . . rather than sophisticated research designs" (Strom & Gingerich, 1993, 82). This model may not empower practitioners by helping them integrate evaluation methodology into their practice, yet there is urgent need for evaluation in which research questions are derived from practice conditions.

Epstein (1995), for one, is critical of the ability of "university-initiated, academic, research-driven programs" to bridge the practice-research dilemma because they:

> more often than not, have little to do with practice or practice settings. Historically these researchers have been more motivated by the desire to prove that practice works (or does not work) than by a need to improve practice (Epstein, 1995, p.84).

His PBR approach (Epstein, 1995), described in Chapter II, was specifically developed to empower practitioners and help them develop rigorous evaluation and learning strategies founded on practice principles and embedded in their everyday work. Epstein's view of the crisis in social work research is that:

> Practice-relevant research, research methodologies must accommodate the norms and ethical principles of 'best practice.' More directly, the challenge posed by the crisis is to develop practice-research approaches that can routinely, unobtrusively, ethically, and usefully be incorporated into decision making at every level at every level of social work practice (Epstein, 1995, 85).

Sidell and collaborators (Sidell et al., 1996) point out that "[e]ffective models that combine social work practice with research are lacking in the professional literature" (p. 100). They describe the development of a group approach in a health setting, over a two-year period, in an attempt to bridge the seemingly dichotomous worlds of practice and research. They conclude that it produced results in the form of publications and enhanced interactions between social workers. They also warn that,

> The process of research takes time and it was with a dawning realization that clinicians recognized the much slower pace of research projects [as compared to] the fast paced, task-oriented practice environment (p. 108).

This dissonance became increasingly apparent in the PBR committee described in my own study, as I will show in Chapter IX.

Epstein, along with collaborators (1995; Epstein, in press; Epstein et al., 1997), has described the use of PBR approaches with social workers and others within health settings, including the use of available data, the development of practitioner research groups, and the development of screening tools. PBR was embraced by the MHP research advisory committee formed within the social work component of the AC. As I will describe in detail later, this evolved, in large part, because of a micro-organizational climate in which some practitioners wanted to shape any research effort that was undertaken. Initially, this group did not have access to resources, including those of academia. As the PBR approach was utilized by the MHP research committee, it was a formative concept in the development of this dissertation project.

A Third Challenge: Effects Management

Additional factors contribute to the lack of direct practitioner involvement in evaluation, design of accountability systems, and research activities. In general, accountability has long created tensions between practitioners and managers and difficulties in role-definition for direct service workers (Grasso, 1986; Grasso & Epstein, 1987, Weinbach, 1985; Weissman, 1983). Even in times of relative stability, measurement of effectiveness - which Grasso and Epstein (1987) call "effects management" - can lead to "ideologically based" conflicts and dilemmas at different levels of organizational practice. These conflicts can be attributed to the different views of how effectiveness is defined within different levels of the organization and to the type of information considered useful by different areas of practice. Managers require types of information different from those that practitioners value, and managers and practitioners greatly differ in their definitions of effectiveness.

> The line social worker, who identifies with interpersonal practice, generally views social workers in administration as not part of 'practice' (Patti, 1983). In addition, the direct service practitioner is likely to focus on helping individual clients, whereas the social worker in administration tends to be concerned with the values of organizational effectiveness and efficiency. While these sometimes coincide, they often conflict (Grasso & Epstein, 1987, 92).

Practitioners can easily fear that effects management will undermine their professional autonomy and managers may fear a loss of control if they involve practitioners in defining what should be measured and how. This can result in the implementation of effectiveness measures that encourage only superficial compliance, rendering them ineffective (Savaya & Spiro, 1997).

The introduction of effects management into agencies can add to existing organizational strains because of the conflict between the conditions required for reflective learning processes and the performance measures. Grasso and Epstein (1987) point out that:

> For persons to learn they must be free to doubt. When pressured to perform they no longer feel that freedom. Instead they feel that they must know what it is they are being asked to do by the agency. The introduction of a measurement system alone places pressure on staff to conceal their practice problems from themselves as well as from their superiors. Clearly this inhibits professional growth" (p. 91 - 92).

It seems self-evident that processes which lead to the concealment of practice problems eventually inhibit organizational growth, learning and adaptability.

Practitioners may easily feel scrutinized and threatened by outcome measures (Savaya & Spiro, 1997). To protect direct practitioners from feeling individually exposed, Weissman (1983) cautions that careful lines need to be drawn between evaluation of effectiveness and evaluation of the individual practitioner's performance, however there is increasing pressure to link the two rather than separate them. Market conditions and changing roles and responsibilities make it imperative that practitioners participate in developing methods to define professional competency profiles - for evaluation of the individual practitioner - that, like a hologram, include the complexities and demands of the practice setting and its overall purpose.

One can conclude that strategies for learning about effectiveness need to be crafted to go as far as possible in addressing the strains between administration and direct practice, and between research methodologies and all aspects of organizational practice. Organizational learning strategies, especially those that involve outcome measures, must bring together practitioners and managers so that they build upon practice knowledge and assist in addressing practice dilemmas. Furthermore, these learning strategies must incorporate knowledge from both research and practice.

3. Assessment Instruments in Social Work Practice

Accountability for service outcomes and the introduction of research methodologies into organizational practice has lead to increasing interest in the development and use of formal instruments in direct practice situations (Ballasone, 1991). As I will describe later, the risk project led to the consideration of the use of existing rapid assessment instruments (RAIs) within the AC practice. These were rejected in favor of innovation through the development of two original, indigenous assessment instruments, the AdQuest and the FamQuest. Therefore, I will describe the most pertinent issues related to innovation and instrument use identified in the literature.

Thomas (1984, 1978, 1975) has written extensively about innovation in human service technology and the organizational factors that support and relate to it. Though his suggestion, that an orderly method for formulating problems, designing interventions and evaluating innovations, differs significantly from the organic and loose design process that gave rise to the risk project, his approach provides a theoretical cornerstone for the methodology used in this dissertation. It is applicable because he identifies the components of organizational systems that must be taken into account by efforts to innovate - including the social, ideological and cultural aspects of organizational life.

Thomas (1984) uses Munson & Peltz's (1982) definition of social welfare organizations as socio-technical systems:

> [I]n which the 'technical' components are procedures for performing activities or delivering services, and the 'social' components are organizational arrangements and human *capacities* that support the performance of these operations . . . [C]hanges in the technical subsystem will require changes in the social subsystem, and vice versa" (Thomas, 1984, p.8).

He focuses on the interaction between technical components (i.e., the procedures for delivering services) and social components (i.e., organizational arrangements and culture, and the practice orientations and capacities of those who provide services). Thomas emphasizes that innovation must address both the human and technical subsystems and that technical innovation cannot succeed without taking into account the organizational and professional culture, values and methods pertinent to the practice setting. He notes that social workers have tended to avoid innovation and to favor the use of existing practice methodologies.

Despite this, social workers have not widely embraced the use of formal assessment instruments just as they have not embraced the use of research methods in direct practice, and they tend to associate the two (Pasahow, 1988). Use of research instruments in social work practice remains controversial. Tripodi & Epstein, (1980) report that many practitioners do not see the value of instruments or research methods, and that those who do fail to find ways to incorporate these methods into their practice.

Pasahow (1989), who studied the implementation of a clinical instrument and client feedback in her own practice of couple psychotherapy, identifies several additional issues that prevent the widespread use of assessment instruments. Among them are the perceptions among those practitioners whose techniques are interpersonal, and derived from contemporary psychoanalytic approaches, that they cannot use feedback from instruments directly with clients as this may interfere with psychotherapeutic processes.

Whether assessment tools can enhance practice is a question. The use of tools to identify high risk clients has been used in planning for prevention and psychosocial intervention, especially in health care systems where not all patients are necessarily seen by social workers. (Berkman, Rehr & Rosenberg, 1980; Becker & Becker, 1986; Wollock & Schlesinger, 1986). Balassone (1991) draws attention to the benefits of risk assessment tools in the field of child abuse prevention.

Where instruments serve as an alternative to interpersonal psychosocial assessment, a question arises, are they equal or superior, and which is more reliable? Balassone offers a research-based methodology for the development of risk assessment tools in social work practice, using an exemplar developed as a risk screening tool on contraceptive use among adolescents. She focuses on three prerequisites.

> (1) the indicators used must predict a defined and measurable outcome (Feldman et al., 1982), (2) the assessment tools should produce accurate predictions of the specific outcome (Milner, 1986), and (3) the indicators must be factors that are reliable and easily assessed in practice settings likely to be visited by the population at risk (Balassone, 1991, p.16).

Yet, as I will describe later, the first two of these prerequisites were not met in the risk project, as the two instruments that were developed were not intended to predict high-risk behavior or to serve *in lieu* of a psychosocial assessment. The purpose was to generate specific, detailed information about individual clients that would help in engagement and discussing of problems, and also provide information for a clinical data base. Tripodi and Epstein (1980) suggest that research methods may be used to enhance clinical practice by improving the quality of information available to practitioners. Evidence that instruments, used as part of interpersonal practice, can assist practitioners by identifying pertinent, overlooked issues has been noted in the literature. Recently, Guterman and Cameron (1998) showed that assessment tools identified exposure to community violence among children who were engaged in psychotherapy. In contrast to the therapists' identification of a history of *family* violence and *sexual* violence, therapist rates of reporting of *community* violence were substantially lower than those reported by patients when an instrument was administered.

As I indicated earlier, introducing instruments in interpersonal practice raises similar issues to the introduction of research or effectiveness measures, and instruments are often considered to be research driven. Savaya, (1996), identifies the many obstacles to implementing structured clinical-monitoring processes in practice settings. Some obstacles relate to organizational issues and others to practitioners' values, methods, and fears over loss of autonomy.

Chief among the organizational factors that make practitioners aversive to assessment and monitoring instruments is that they are rarely given adequate time, training and preparation for these "new" methodologies. Organizations often fail to create an atmosphere conducive to such innovations and even practitioner self-monitoring of their practice effects is seen as intrusive, irrelevant, as extra work, as a threat to their autonomy, or all of the above.

Savaya and Spiro (1997) see practitioners as generally reluctant to conduct formal monitoring of their own practice preferring informality. Even when grasping the potential benefits of instruments and research methods, practitioners feel that the time and effort involved is not worthwhile and that the benefits are not concrete and useful to their practice. Practitioners are generally unfamiliar with instruments and tend to see them as "blunt or irrelevant" (p. 41) and as antithetical to the human qualities of direct practice. Likewise, Rubin and Babbie (1989) note that social workers see formal measurement of problems and outcomes as cold, and in conflict with the warm, intuitive, spontaneous aspects of interpersonal practice. This view may be reinforced by the fact that instruments are developed on the basis of shared characteristics and much of practice is geared to understanding the unique individuality of the client. Bloom and colleagues (Bloom et al., 1995) point out that practitioners also fear that measurement will leave their weaknesses and practice problems exposed.

Savaya and Spiro (1997) described an intensive and concerted effort to address these pitfalls in introducing a standard instrument to monitor client outcomes in a family counseling center. This included an extensive effort to train staff in self-monitoring and to integrate their concerns and ideas into the process in supervision. A high level of interchange was encouraged and adjustments were made to the instrument in response to practitioners concerns. They describe the project in the following way:

> On the face of it the project had good prospects for success. A sensitive and relatively easy to score instrument that seemed to fit the agency's treatment approach had been chosen. At each stage of its introduction, the counselors were queried, their objections considered and solutions sought with their active involvement. The training focused on both the technical aspects . . . and the counselors emotional and cognitive reservations . . . At an early stage . . . [their objections] . . . seemed to have been answered and its value and importance seemed to have been accepted (Savaya & Spiro, 1997, p. 51 -52).

Nevertheless, they report that they were unsuccessful. The agency eventually introduced "monitoring by fiat" (p. 50) having failed previously to convey adequately that monitoring was an important priority. They describe a vicious cycle in which practitioners concluded that monitoring was irrelevant to them as long as it did not produce information that could be integrated into their practice, and their failure to comply ensured that it could not be integrated into practice. They caution that monitoring by fiat can produce superficial compliance and in their case study practitioner compliance was not improved.

4. Conclusion

The practice environment is changing rapidly and with it come changing responsibilities and roles for practitioners and new challenges to managers. Practitioners must be able to articulate the purpose and benefits of what they do, and to embody programmatic purposes in every aspect of daily practice activity. Managers, practitioners and researchers must work together to better define social work practice and services, to develop a unified and shared agenda, and to develop evaluation strategies relevant to the new market conditions. Paradoxically the new market conditions, while they make collaborative organizational learning strategies imperative, also exacerbate longstanding divisions. These include strains between managers and practitioners regarding professional autonomy and control, strains between academia and practice regarding what is seen as a relevant focus for research and evaluation, and strains between practice methods and evaluation methods regarding a range of issues. One particular issue is the use of evaluative tools and instruments in practice, which raises conflicts over practitioner autonomy, administrative control, confusion between program evaluation and the evaluation of the individual practitioner, among others. In this study a choice was made to develop a partnership within the agency that included practitioners, managers and a PBR consultant/educator. From that partnership several projects emerged, among them the development off clinical instruments that were original, indigenous and practitioner designed.

Chapter IV. The Challenges of Serving Adolescents, Notes from the Organizational Setting and from the Literature

1. An Overview of the Chapter

In the previous chapter I addressed factors in the organizational environment that contribute to the argument that social workers should develop models for enhancing organizational learning. In this chapter I will address a second set of problems that contributes to this imperative. These are the practice problems that specifically relate to defining and identifying adolescent risks.

In this case study interest in improving the assessment of adolescents grew from particular problems that arose in the agency setting. Therefore, in section two, rather than begin with a review of the literature, I first describe the organizational setting - the AC and its auspices, its staff and clients, and the Medical Center within which it is organized. After describing the AC, its mission, service scope and funding, I describe its Behavioral and Mental Health Program (MHP), within which its social workers practice. Next I describe the broader professional context of social work within the Medical Center and the impact of the organizational environment on the MHP. Last, I describe the MHP's staff and clients, its organizational culture and human service technology.

In section three I address the issues involved in understanding and assessing adolescent risk. To do this, I first describe the research literature on adolescent risk and the varied perspectives on risk that are current. In section four I relate this literature to the practice challenges that were defined in the agency setting and briefly describe some preliminary studies conducted in the early nineteen-nineties. A fuller description of these studies is included in Chapter VI when I describe their impact on the development of the MHP research committee. I conclude by describing how organizational learning strategies can help shape responses to these challenges.

Throughout this chapter I refer to an array of agency documents, including strategic plans, business plans, grant reports, program descriptions and other reports, that were available to me by virtue of my managerial location. For simplicity, I use numbered references and list these documents in Appendix A, "Agency Sources."

2. The Practice Setting: The Adolescent Center and its Auspices

The organizational setting for this study is the mental health component of an adolescent health center, a freestanding component of a large, nonprofit, voluntary hospital and medical school. Together the hospital and medical school constitute a twelve hundred bed, academic medical center. Located in the heart of one of the largest U.S. cities, the Medical Center (as I will refer to it) sits between two neighborhoods that represent the wealthiest and poorest inner-city neighborhoods in the United States (Peake, Brenner & Rosenberg, 1998).

Over the last five years the Medical Center has emerged as a growing, multi-centered "Health System," a network of affiliated hospitals and health services developed in response to market forces that were reshaping organizational arrangements of national health care (Banks, 1998). This goal of growth was based on a theory that only larger systems would survive in the health care financing environment that was emerging in the nineties, and reflected the tendency toward corporatization in nonprofit health care, noted in the literature (Dinerman, 1997). In 1999, after four years of discussion and restructuring, this Health System completed a merger with another nearby academic medical center, to become one of the largest medical centers in the nation (31, 32). The combined annual budget of the combined Medical Centers two hospitals - without the affiliated institutions within their Health System network was approximately $1.8 billion in 1999.

At the time this study was initiated, the AC had been established for more than thirty years. In that time it had grown from a small, interdisciplinary health team into one of the largest and most comprehensive adolescent health centers in the US. In 1999 it provided more than 45,000 client visits to young people, between 12 and 21 years old, living in the inner city. The AC's 1999 mission statement is as follows:

> The [AC's] . . . mission then, is defined by the needs of our population and is in keeping with the mission of . . . [the Medical Center]:
> ***Service:*** To prevent disease in adolescents, to educate and treat adolescents through provision of comprehensive primary care, mental health, reproductive health and health education services.
> ***Training and Education:*** To educate patients, families, health care professionals, health care workers and the community.
> ***Policy Development and Research:*** To develop and influence health policy, to participate in research and disseminate information regarding effective service, treatment and prevention methodologies for adolescents and their families in their communities (8).

The AC is also a component of the Medical Center's School of Medicine. The AC is synonymous with the Division of Adolescent Medicine, a Medical School entity organized within the Department of Pediatrics. Despite this organizational arrangement the AC's focus, since it was founded in 1969, had been on services. Although AC physicians had faculty appointments within pediatrics, and the AC was one of the first adolescent medicine programs in the nation, academic activity took second place to services, and research took a distant third place. Of the more than twenty grants that the AC had in 1998, only one was for research and its principal investigator was a faculty in another institution. Social workers and other non-physicians at the AC did not have School of Medicine faculty appointments during the time this case study was conducted.

The need to strengthen the AC's academic and research platform was acknowledged in 1997, by its Director, a physician who was also the Division Chief for Adolescent Medicine. There were two immediate reasons for this. First, a new Chairman was hired for the Department of Pediatrics, and he made clear that he wanted to foster physician research. Second, though the AC had one of the first adolescent medicine fellowship training programs in the nation, in the mid nineteen-nineties the American Academy of Pediatrics (AAP) decided that adolescent medicine training programs would become more intensive, more research oriented and more regulated. The AAP decided that it would recognize only formally approved three year academic fellowship programs, and that the formal approval process - which would take effect in 1999 - would require that programs have strong academic research (30).

During the time that this case study was initiated, I was involved in planning for the development of an AC Research Unit (ACRU) and in the formal application for AAP approval of the AC's Adolescent Medicine Fellowship Training Program. Because this effort was not pursued vigorously until 1998, it had little direct bearing on the events described in this case study until late in that year. Then the AC Director and I developed a funding plan for research personnel and began to consider the creation of the ACRU. An ACRU director was hired in August 1999 after this case study ended. I will describe the impact of this development on the MHP research committee in Chapter IX.

Throughout the early nineteen-nineties, I was responsible for overall strategic planning for the AC and these efforts focused largely on service planning until the late nineteen-nineties when research and policy became a focus. In 1992, the AC's three senior managers, of whom I was one, began its first strategic planning process, completed in 1994. This was also the first strategic planning conducted in a component of the Medical Center since the nineteen-seventies and this effort made the AC highly visible in the Medical Center for the first time in the AC's history. One significant result was that in 1995 the service moved to a newly designed, larger facility. At that time the AC also initiated a series of business plans, in order to secure institutional support for expansion and enhancement of services. In 1998 I was also assigned the responsibility of developing an AC Advisory Board that would be linked to the Boards of Trustees of both the Medical Center and School of Medicine. Correlative with these planning processes, a wealth of planning documents and official program descriptions were generated between 1992 and 1999.

A review of these documents (1, 2, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20) reveals that the AC's growth began in the early to 1980s and increased momentum in the 1990s. Initially, this growth was spurred through grant awards for services to address emerging adolescent problems such as substance abuse prevention, school health issues, reproductive health and AIDS prevention. In 1990 the AC's budget was approximately $1.6 M, with $1.3M of this being in grant support and $300,000 in institutional support. Successful strategic planning efforts initiated in 1992 led to an increase in institutional (non-grant) support for personnel from approximately $300,000 per annum in 1992 to more than $3.3 million per annum in 1997. The AC's current, annual personnel and supplies budget is $7 million.

The AC's staff, of approximately eighty people, provides a broad range of services to adolescents, and education and training to health care professionals. Despite its threefold mission, the AC has been largely focused on service provision. While teaching and training activities were increased between 1990 and 1998, until 1999 there was relatively little research activity occurring (1, 2, 18).

Since 1990, I have been one of the AC's three senior managers and its Assistant Director for the past nine years. (A fourth senior manager - the ACRU Director was added to the AC Management Group in the summer of 1999). Additionally, I am a senior manager in the Medical Center's Social Work Department. During the time the risk project was initiated I was responsible for the AC's planning and program development, the grants and development office, and for the MHP.

Medical services provided to clients include comprehensive primary health care, urgent health care, reproductive health care, chronic care, specialty care, HIV/AIDS services and nutrition services. These services accounted for approximately 23,000 visits in 1999 (1, 2). Mental health services, with which this study is concerned account for the other half of the AC's activities. These services provided 22,000 visits in 1999 and are organized under the MHP (1,2).

The Adolescent Center's Behavioral and Mental Health Program

The MHP is the component of the AC that, between 1993 and 1998, saw the most growth and change (1, 2, 20). In 1990 a mental health team of thirteen social workers and a consulting psychiatrist, provided services largely confined within the walls of the AC (16, 17). By 1999 the AC had expanded in every capacity (1, 2, 20). A staff of more than thirty mental health workers and ten health educators, provided a broad range of services within the AC, in ten schools and in off-site community locations (1,2).

In 1988 mental health services, included early intervention, crisis intervention, ongoing counseling and support services, psychological and psychiatry services, substance abuse prevention, violence prevention and treatment services, including sexual abuse and rape services, and services for HIV infected and affected adolescents. In addition, extensive outreach, and education was provided to communities, organizations and other professionals.

In 1998, this range of services was provided by twenty-two M.S.W. social workers, two psychologists, two psychiatrists, a social work assistant, and four support staff. Many social work practitioners were also involved in a wide array of non-clinical activities related to training, education, technical assistance, and program development. Health education and peer-based services, provided by ten health education staff and sixteen trained adolescent "peer educators" provided services to an additional volume of clients. These services included health education, risk reduction, risk prevention, and community and street outreach services.

The Broader Professional Context: Social Work Within the Medical Center

Twenty-two of the MHP staff are social workers; social workers were instrumental in forming the research committee and the risk project. In turn, I will describe the wider organizational culture, and the Social Work Department, and its impact on social work practice. I do this only briefly here as, in Chapter VI, I offer a fuller account of developments within that core professional department and their effect on the MHP research committee.

In the nineteen-eighties and nineteen-nineties, the Medical Center's Social Work Department prided itself on a reputation for outstanding achievements and leadership in the field of practice, research, and program development (Blumenfield, 1995; Rehr, Rosenberg & Blumenfield, 1998; Rehr, Rosenberg & Showers, 1998). With a large staff - more than one hundred and fifty social workers in 1998 - this department experienced a significant "flattening of the administrative and supervisory structure during the nineteen-nineties which led to increasingly complex, multifaceted roles for direct service social workers" (27).

By 1997, the roles of the social work direct practitioners within the MHP included a wide range of responsibilities. Many combined clinical supervision, program development, accountability, reporting, and program coordination work with direct practice. More than one-third had significant program development or coordination responsibilities for the many grants that supported the overall program, and the activities of less than one-third of the practitioners were restricted to direct practice only. In 1997, with only one social work supervisor for the MHP group, individual supervision of social workers was divided between eight individuals, six of whom were direct service staff, suggesting a relatively "flat" and decentralized supervisory structure. Many had postmasters training - four were doctoral candidates and seven had completed post Master's certification in psychotherapy. As of the fall 1998 the rate of social worker retention at the AC was higher than for the Social Work Department overall (Bernstein, personal communication, July 8, 1998), with average retention of more than five years. (This average included three new practitioners hired into newly created positions in that year). This retention rate may have reflected the desirability of the setting as one, of few, where staff could conduct ongoing psychotherapy with clients with no limits on length of service or modalities offered other than those imposed by clients themselves (27). The MHP's extensive grant funding made this possible as it allowed the MHP to avoid the restrictions on service utilization imposed by managed care and Medicaid caps.

The Impact of the Fiscal Environment on the Adolescent Center's Mental Health Services

In 1994, the Medical Center began a process of "re-engineering" and "downsizing," driven, in part, by a need to create capital for expansion and in part by reductions in health care reimbursement (Banks, 1998). This process intensified exponentially during 1998 and 1999 with the expansion of the Medical Center's Health System and its merger with another large medical center, described earlier. The environmental pressures currently affecting health and social services, identified earlier in Chapter III, came into play in the Medical Center during the last few years and continue today. Financial pressure has been the norm in all divisions of the Medical Center, as has concern over increased scrutiny of the fiscal "bottom line." Behavioral and psychosocial services, particularly social work services, have been very heavily scrutinized.

A highly aggressive strategy of grant development at the AC helped in program growth and in insulating services from the financial cutbacks prevalent in the larger organizational environment. This effort, which was accelerated after 1992, focused on developing services to address emerging adolescent problems and on broadening the range of services, available modalities, and staff mix (1, 2, 10, 11, 12, 13, 16, 17, 18, 19).

By 1999, the MHP was supported by funds from eleven different government grants and two Medical Center budget sources. Diversification of funding has led to increased need for accountability, both generally and in response to the specific and unique requirements of each funder. One effect of this has been an increased need for data regarding client profiles, client risks, services and outcomes. Despite this need, the AC, like the larger Medical Center, does not yet have an information system that provides comprehensive data on client characteristics, utilization and outcomes. As a result, one program-related goal of the risk project was the development of a data base that would help build such an information system.

During the nineteen-nineties grant funding protected the MHP from constraints on services imposed by insurers and Medicaid or by a client's lack of any insurance - 40% to 50% of all clients. Though these constraints are a factor in planning for future growth, they have not limited the MHP's ability to offer ongoing services to adolescent clients regardless of their insurance status or ability to pay. Within the MHP clinical practice has been largely unaffected by external changes in the fiscal environment. Freedom from the constraints on service utilization has meant that the MHP has not had to embrace time-limited approaches to treatment. Neither have external funders called for a justification of any individual client's treatment plan, as occurs under managed care. The diversity of funding sources allows the MHP flexibility in assigning clients to different services despite the eligibility criteria of any one grant.

Increased staff productivity was one MHP management focus between 1996 and 1999. In the fall of 1996 I established a task force of six direct service practitioners and a social work supervisor to study ways to enhance productivity. One recommendation from this group was that group pyschotherapy services should be increased to enhance both productivity and clinical care. Medical Center mandated audits of staff productivity done in spring 1997, by one of the country's largest business accounting firms, heightened awareness of this issue throughout the AC. The hiring of an expert in group development, group supervision, and staff training in group pyschotherapy skills, led to a large increase in group services. Yet, group work remains a "secondary" modality and, for most clients, it is still an adjunct to individual casework.

Clients and Staff: Organizational Culture and Organizational Technology

The AC serves predominantly poor and working class adolescents of color; ages, twelve to twenty-one years. Sixty-nine percent come from adjacent, impoverished, largely Latino and African American, central city neighborhoods. Clients are 46% African American or Afro-Caribbean, 46% Latino, 5% white and 3% Asian (6). A June 1997 survey of mental health service charts showed that staff noted the following client risk factors: 51% showed school problems of some sort, 66% lived with a chemical abuser, 28% acknowledged having used marijuana or harder drugs, and 20% reported the regular use of alcohol (4, 15). Given that this data is drawn from chart surveys one can assume that the prevalence of risk factors is even higher than those reported.

One AC survey (Diaz & Manigat, in press) of females seen for medical services, showed that 34% reported some history of sexual victimization. Among adolescent females seen for reproductive health services in 1997, 79% reported being sexually active, 39% had been pregnant, of whom 40% had a history of two or more pregnancies (6). Clearly, available data suggests that, in the nineteen-nineties the AC served high-risk adolescents. However, given the sketchy and partial nature of these data, the development of a more rigorous, program-wide, clinical information system and the clinical, programmatic use of such information was a logical step in organizational development.

Although the AC's official Mission Statement declared that adolescents were seen confidentially, it is unclear how many clients were seen without the knowledge of their parents due to the lack of program-wide data. Many adolescents who were seen for reproductive health services may indeed have been seen confidentially as allowed under state law. The AC made no effort to seek parental consent to care, except in the MHP on occasions when the psychiatrists wanted to prescribe psychotropic medications to clients who were minors. The power organizational metaphor was that adolescents would be seen confidentially for any services that they needed. Later on, in Chapter X, I will describe how I came to understand the function of this metaphor in that it allowed considerable leeway to practitioners in engaging clients, even those whose behaviors seemed high risk. This in turn enabled the AC to make easy access to confidential care a powerful means with which to attract high-risk adolescents into services.

The vast majority of MHP clients under the age of eighteen who were seen for mental health services had some parental involvement. Despite an organizational culture that stressed that clients were seen without parental consent, a 1992 survey that I conducted revealed that less than 1% of MHP clients younger than 18 years old were being seen without a parent's knowledge. In 1997 parents were involved in the assessment process of more than 85% of all MHP clients under the age of eighteen (5).

Official MHP intake practices focused on reducing barriers to client engagement by having an assessment process that balanced "rigor" (a full psychosocial history) with "relevance" (a problem-focused intake). By 1994, this process involved three assessment sessions conducted by a social worker, followed by a review by one of two interdisciplinary treatment planning teams. By mid-1997 there four teams, three of them led by social workers and one by a psychologist.

Available data on client utilization are sketchy. Data obtained from a grant funded component of the MHP - for clients first admitted between July 1996 and June 1997 (4) gives a crude picture of service use. Approximately 32% of clients dropped from services within the first two assessment sessions. (Less than 3% were referred elsewhere). Of those who remained and became clients, about 22% were seen three to six times, 32% seven to twelve times, and 37% thirteen to forty times in that twelve-month period. As this survey looked only at clients whose first admission occurred in that twelve-month period, it tells little about re-admissions or about those clients who were still active in services and may have continued with services. About 8% to 11% of clients engaged in services that extend longer than an eighteen-month period. In fact, the absence of reliable utilization data was one factor that influenced the development of the risk project.

3. Notes from the Literature:

Understanding Adolescent Risk

It is reasonable to assume that both assessment of individual client risks and identification of broad risk groups are necessary for the development of holistic intervention strategies. Yet, considerable ambiguity remains as to the issue of whom among adolescents are at risk and how to identify them (Stanton, Fang, Li, Feigelman, Galbraith & Ricardo, 1997). Even with adequate data on specific risk factors, assessing adolescent risk properly is difficult due to population-specific norms of behavior. Adolescents, overall, have been described as "a population at the crossroads" of good and poor health outcomes (American Medical Association [AMA], 1993, p.1). They are a high risk population with an enormous potential for promotion of healthy behaviors (Dougherty, 1993; Millstein, Irwin & Brindis, 1991).

Research and literature on adolescent risk has been fragmented into specific problem areas such as violence, sexual activity, teen pregnancy, and substance abuse (Dougherty, 1993). Funding streams have been similarly fragmented. Since the middle of the nineteen-eighties there has been interest in understanding adolescent risk from a more holistic perspective derived from empirical studies, and in the development of a theory to explain risks so that prevention can be enhanced. I will describe the three theories that have been most influential in the last decade, in the order in which they emerged. Each was derived from longitudinal, quantitative studies.

Problem behavior theory (Donovan, Jessor & Costa, 1985; Jessor, 1991) suggests that adolescents who are attracted to one risk behavior will be attracted to others. Dryfoos (1990), in particular, suggests that risk behaviors cooccur in large numbers of adolescents, with the same "high risk" groups engaging in multiple risk behaviors. Gateway theory (Kandel & Yamaguchi, 1993) suggests that adolescents engage in escalating risk behaviors. It has been particularly influential in substance abuse prevention programs. One area of interest that is evolving from this perspective is the study of risk antecedents and markers (Resnick & Burt, 1996). Most recently, serial risk behavior theory (Stanton et al., 1997), suggested by longitudinal studies of long-term risk behaviors has looked at the endurance of risk behaviors. This theory suggests that many adolescents shift from one risk behavior to another over time, with no apparent escalation of risk behaviors.

Because much of the research on adolescent risk has been concerned about individual behavior patterns, too little is understood about social and environmental influences. While all of the theories offered above have found considerable support in the research, the many contradictions between them mean that a "unified" theory of adolescent risk is not likely to emerge. No one theory appears applicable to adolescents overall and there are many suggestions that more needs to be understood about the specific ways risk factors affect different subsets of the adolescent population, particularly in terms of the influence of community and family contexts (Mechanic, 1991). Adolescents who seem low-risk in their own behaviors might be at risk due to the behaviors of friends and associates (Bailey, 1992), or due to social factors rather than individual risk behaviors (Kadzin, 1993; Powers, Hauser & Kilner, 1989; Zazlow &

Takanishi, 1993). Risk behaviors may also have different consequences for different subgroups though this also has received little attention so far (Shapiro & Seigel, 1998).

Problem behavior theory has been influential in identifying a taxonomy of risk-level based on behavioral patterns that has been influential in the field of adolescent medicine, which has only emerged as a medical specialty over the two decades. This may be because it offers a way to assess risk in the individual adolescent - seen in an agency or physician's office - simply by quantifying the number of risk behaviors that the adolescent reports engaging in.

Nevertheless, a dichotomy exists between the clinical construction of adolescence, as a phase of life, and recent research on adolescents. Clinical lore and practice wisdom has focused on adolescence as a period of storm and stress, on adolescent feelings of invulnerability, and on conflict with parents. Many recent studies question these popular "myths" (Eccles, Midgely, Wigfield et al., 1993; Kadzin, 1993; Offer & Schonert-Reichl, 1992; Zazlow & Takanishi, 1993; Powers, Hauser & Kilner, 1989) and suggest that adolescents may not be more troubled than other age groups.

In addition, several studies suggest that adolescents are far better assessors of risk and better reporters on their own problems than has been assumed (Andrews, Garrison, Jackson, Addy, C. L. & McKeown, 1992; Cohn, McFarlane & Yanez, 1995; DuRant, Seymore, & Jay, 1991; Graham & Rutter, 1973; Kadzin, 1993). An overemphasis on "developmental turmoil" might be one reason few studies compare adolescents with other age groups. Too little is understood about the broader social and institutional factors that may contribute to risk (Eccles et al., 1993; Fahs et al., 1999).

Reviewing twenty years of research on adolescent risk to recommend priorities for future research on adolescent development, Zaslow and Takanishi (1993) draw the following conclusions. Many adolescents engage in activities that present serious risks to their health and safety resulting in a critical need for interventions for adolescents, with 15% at high risk and another 10% at very high risk. Minority youth have been inadequately studied. Considerable progress has been made in the amount and quality of research on adolescents over the last fifteen years, but it has also underlined the extensive gaps in knowledge. Research has challenged many assumptions that were based on clinical experience and that overemphasized the theory that "adolescent invulnerability," a psychological characteristic of the developmental phase of adolescence, caused the population to engage in high-risk behavior. One result is that explanatory theories of adolescent risk have under emphasized the contribution of social factors and institutional arrangements to the creation of vulnerability in the adolescent population as a whole.

While adolescents may be overconfident and under informed, and those who engage in high risk behaviors may have poor assessment of the consequences and risks of their behaviors, the theory of adolescent invulnerability, common in literature, is not supported by studies (Benthin, 1988; Jacobs et al., 1993; Millstein, Irwin & Brindis, 1991). Zaslow, and Takanishi (1993) conclude that there needs to be much greater understanding of the adolescents' perspectives on risk and a broader collection of data that reflects adolescents concerns, including qualitative data that explores the meanings they assign to risk behaviors. One explanatory theory that they discuss is "stage-environment fit," which suggests that there is need for greater understanding of the developmental needs of adolescents and for ensuring that our social institutions are well tailored to their needs.

The emerging picture of "normal" adolescence and adolescent risk may offer little comfort and clarity to direct practitioners because it remains full of contradictions. Neither practice wisdom nor research studies alone provide an adequate basis for developing relevant, rigorous, comprehensive assessment tools. Risk assessment strategies, and ultimately funding strategies, must be predicated on a better marriage of these areas of knowledge and must be tested in real contexts.

4. Views of Adolescent Risk Within the Adolescent Center

A review of the AC's official documents (2, 3, & 8 - 21) suggests that the organizational culture reflects the contradictory picture developed in the literature. The espoused organizational theory of "help" is that adolescents should be viewed as "sensible and responsible good consumers of health care" (8). Two unpublished studies of the MHP, conducted by staff, (Mirabito, 1996; Peake, 1991) suggested that direct service staff's orientations toward clients did not fit well with actual client behaviors. However, while adolescent clients use the MHP for relatively short episodes of help, most direct service staff members maintain the idea that clients need long-term intervention. In other words, many staff members appear to view clients at high-risk and highly vulnerable and they define clients' needs quite broadly and holistically. By Contrast, in as much as utilization patterns are a measure, clients seem to define their needs more definitively based on the immediacy of their presenting problems. Mirabito concluded:

> [C]linicians believed that there was a significant gap between their own and the clients' view of treatment. In contrast to the concrete, problem-focused, and crisis-oriented approach to treatment that staff believed adolescents preferred, they had a clear preference for insight-oriented longer-term treatment. . . . [T]here was often a lack of consistency and mutuality between their goals and their clients'. Staff believed that this . . . Contributed to the tendency for adolescents to dropout or leave treatment without a process of closure or termination (Mirabito, 1997, p 3).

My own study (Peake, 1992) found that practitioners struggled with contradictory views of their clients. At times they viewed clients as responsible and competent even if they seemed troubled or confused. At other times practitioners were burdened by their own awareness of their clients' non-responsible behaviors, poor judgement and unpredictability. In turn, practitioners bore the weight of these worries like a parent, yet remained constrained to not express these worries to parents by their professional role within the context of a confidential adolescent service. Both Mirabito's and my own study showed that these kinds of problems led to frustration and feelings of failure for staff.

The apparent differences between practitioners and adolescents, in terms of how each group seemed to define the "need for help" overall, make it difficult to define appropriate services for adolescent clients and merit further study. I will describe these two small-scale, qualitative studies and their influence on the development of the research committee in more detail in Chapter VI.

Chapter V. Study Design and Methodology:
The Exploratory and Descriptive Organizational Case Study

1. An Overview of the Chapter

The current case study is an approximation of an AB design in which the impact of an organizational intervention, introduced in 1996, is studied using a retrospective analysis in order to develop a prescriptive organizational plan. The intervention took the form of an evolving process in which PBR methodology led to the design and implementation of the adolescent risk study. As such it was not introduced at a single moment in time, but was ongoing, multifaceted and "loose." This approach has its practice analogue in Schon's (1983) concept of the frame experiment where the investigator-practitioner is a participant in a context where she or he has little direct control over most of the "variables." As a driving force in the daily life of the MHP, as founder and co-leader of the research committee, and as one of the staff who developed the risk project, I was a participant observer.

In this chapter I describe the investigative methodology used. In section two, I present the rationale for organizational case studies, such as this one using Reid's (1979) and Thomas's (1984) models for single case studies of organizational and service innovations. In section three I describe the case study methodology for this dissertation study utilizing Yin's (1989) outline for case studies, as follows: The unit of study and a framework for definition of its component elements at different points in time, using the Differential Program Evaluation Model (Tripodi et al., 1979); the question in the form of explicit assumptions made during the origin of the risk project about its desired impact;

data sources, and the methodology for research analysis. I derive the methodology for analysis from Epstein's (1995) suggestion as to how PBR methodology and the reflective practice paradigm can be integrated for clinical case study.

I end the chapter, in section four, with a discussion of the limitations and strengths of the reflective participant-observer methodology used in this case study. Though observer bias and questions regarding the reliability of the data are hazards of this approach, I describe how I followed the precepts of Grinnel (1997) and Patton (1990) to ensure that these hazards are minimized, including the use of multiple data sources and viewpoints. I use the literature to illustrate that the concept of the participant-observer is integral to the reflective practice paradigm and is a naturalistic research methodology that is particularly appropriate for this study of everyday agency phenomena and their meanings.

2. The Case for The Case Study of Organizational Innovation

This dissertation project is a single case study of an organization. It is exploratory and descriptive. It is both retrospective and prescriptive, ending with a planning process for continued organizational development. It has the goal of studying the processes of organizational development and innovation and as such combines the Developmental Research and Utilization (DR & U) 1984 model of Thomas and the "Model Development Dissertation" (MDD) of Reid (1979).

In Reid's (1979) view, the study of organizational and service innovations is a neglected aspect of doctoral dissertation study. One reason for this is that the explorative study of "loose" organizational processes has not been given sufficient recognition as a worthwhile endeavor out of concern that such a method lacks academic rigor. Nevertheless, Reid suggests that these seemingly loose methods can contribute to the rigorous development of programs and interventions. Reid offers the MDD model to suggest dissertation studies of organizational innovations. MDD uses a single case study methodology that approximates an AB design.

Like Reid, Thomas (1984) also is concerned that social workers have been reluctant to develop and study innovations in human service technology. Although human services deal with arrangements and human capacities that can be difficult to measure, Thomas emphasizes that practice and research are highly compatible when the practice context is used to define appropriate research questions and methods. DR & U proposes that the design of innovations be grounded in information gathered from fundamental sources that social workers routinely utilize. These include professional practice, technology, and human experience.

In this dissertation study, the innovation was developed through a highly "organic" process, which included the development of a PBR group, and later, the design and implementation of the risk project. Not until the risk project design was well underway did I plan this dissertation study of its design and implementation. Therefore, in contrast to the prospective designs proposed by Reid and Thomas, the method used here is largely retrospective.

3. The Reflective, Retrospective Case Study Methodology

Robert Yin (1989) defined case study as:

> [A]n empirical enquiry that . . . investigates a contemporary phenomenon within its real life context; when the boundaries between the phenomenon and the context are not clearly evident; and in which . . . multiple sources of evidence are used . . . [and it is an appropriate methodology when] . . . "the investigator has little control over events, and when the focus is on contemporary phenomena within some real life context (Yin 1989, p.23).

He views case study methodology as particularly useful in organizational and management studies where the unit of study is an implementation process, a program or a decision.

The Unit of Study

Yin (1989) suggests that defining the beginnings and endings of case studies of organizational processes is difficult and somewhat arbitrary. When I began this study, the proposed unit of study - the risk project - was the evolution and impact of a PBR project first developed to enhance client assessment, interventions and service design. Its development was understood to be an incremental process with multiple determinants and no easily identifiable beginning. An iteration of the origins of the risk project, and the practice assumptions contained in them, was to be a key element of the study's findings.

It became evident, as I continued, that the unit of study must be widened to include the formation of an MHP research committee within which the risk project was initiated. Upon reflection, I see that I had underestimated how intertwined the histories of the two had been and had assumed that the research committee was, simply, the crucible within which the risk study was initiated. I found that the risk project's scope, the timing of its initiation, the shape it took, and the speed and methods of its implementation, were profoundly affected by the research committee's own developmental processes. As I will describe in the next chapter, many factors that contributed to the creation of the risk project had been in the organizational climate for some years. Only when the research committee was created as a vehicle to focus and iterate these factors and create action on them could the project go forward and, even then, only when the committee was sufficiently established.

The period under study spans almost eight years overall, as it included four years that preceded the creation of the risk project. This extensive length of time, combined with the complexity of describing many interlinked organizational processes, meant that a framework was needed to define developmental stages. Tripodi, Fellin and Epstein's (1979) three stage Differential Social Program Evaluation (DSPE) model for conceptualizing program development and evaluation is an appropriate framework for describing the evolving historical process in this study. Tripodi and colleagues describe these phases in the following way:

> *Program Initiation* refers to that stage in which the ideas for a program are translated into a plan of action and in which necessary resources are secured. It involves all of the planning and preparation required before the content of the program can be delivered . . .
> *Program Contact* is that stage in which a program has achieved its objectives of initiation and is devoting its efforts to the active engagement of a target population with the program staff . . . In this stage of development, program directors are concerned with locating physical, social and psychological obstacles to the delivery of services . . .
> *Program Implementation* is that stage in which a program having achieved the necessary conditions of initiation and contact applies its technology services and so on toward the attainment of ultimate program goals (Tripodi et al., 1979, p. 7).

Bielawski and Epstein (1984) expand upon the DSPE model by adding a phase Program Stabilization. This is the phase in which the process of securing and stabilizing the innovation is addressed and its overall effectiveness can be assessed. They describe Program Stabilization as:

> the point at which the program achieves a degree of autonomy form its external environment . . . Autonomy means the extent to which a program possesses a distinctive area of competence . . . undisputed jurisdiction over a function, service, goal, issue or cause . . . Autonomy gives an organization a reasonable claim to resources and thus places in a more favorable position to compete for resources . . . In the stabilization phase the program's continued existence is not in question and it has successfully accomplished the tasks embodied in each of the prior stages (p. 17 - 18).

The DSPE model is a heuristic and adaptable one (Epstein, private communication, July 29, 1999) and because the risk project evolved in a somewhat organic rather than planned manner, I added a phase, the Pre Rational Phase: This term describes the origins of the risk project, and research committee, in organizational processes that were occurring long before any focused innovation effort was considered. It is important to note that it is difficult to draw neat lines between phases when describing complex organizational processes, and the phenomena I study have considerable overlap in their development.

And so, within my own expanded framework, the unit of study included the following organizational processes:

The Pre-Rational Phase: the development of the PBR group, the factors within the organizational context that influenced this development, and the development of interest in enhancing assessment practices;

The Program Initiation Phase: the risk project design process - including key decisions, value conflicts, instrument design - and the ongoing research committee process;

The Program Contact Phase: the introduction of assessment instruments to AC practitioners, the piloting efforts with clients, the ongoing research committee process, and the impact on other organizational processes;

The Program Implementation Phase: the introduction of the project into the practice and its continued impact on the organization, including planning processes and related projects that emerged. This last section will also include the planning process for full implementation.

The concept of Program Stabilization is used prospectively in the concluding chapter of this study as a framework for evaluating the status of the risk project in June 1999, when this case study ended. The project had not yet achieved stabilization, as this depended on the restructuring of the research committee. The characteristics of stabilization are used to consider the future of the risk project through the creation of a clinical information system.

The Research Question

Yin (1989) identifies a main component of a case study as the propositions that underlie the intervention or phenomena being studied. These propositions are not formal hypotheses, but are the implicit and explicit assumptions that are at the heart the project. In a reflective approach (Schon, 1983; Epstein, 1995; Fook, 1997) propositions are not laid out before action but are derived during the investigative process and are inseparable from intervention. This creates a problem in distinguishing between the methodology and the phenomena being investigated, as they interact and co-evolve. Following Schon's (1983) method, I will iterate the explicit and implicit assumptions being made by the participants in this process during each phase, to provide a series of timed snapshots.

The core questions at the heart of this study are the assumptions that were the original premises for creation of the research committee and later the risk project. *Meta-assumptions* were that development of reflective organizational learning processes would lead to enhanced organizational effectiveness and that PBR would be an effective vehicle for this. *Specific assumptions in the form of goals and objectives* were as follows: (1) The risk study would enhance assessment of individual clients by providing information that was not routinely obtained in the interpersonal assessment process used in the MHP at the time the project was initiated. This included information about each client's risks, behaviors and attitude to help; (2) The resulting aggregated information about clients would provide broader knowledge of the client population and assessment approaches that would otherwise not be routinely available to direct practitioners, and; (3) Emerging information would allow for identification of strengths and deficiencies in service approaches, and would enhance program development.

Data Sources

The risk project generated data about adolescent clients but this was not the focus of this study. Rather, because I set about to evaluate the impact of a PBR design process and the implementation of assessment instruments, the data that were most relevant to this project took the form of organizational processes, experiences, decisions, and the effects they had on people and practices. Primary sources of data were as follows:

Research committee minutes, notes and reports.

The research committee was formed and implemented long before I considered this dissertation study. Minutes and notes on the committee's work were utilized as a primary data source, including notes regarding the committee's structure, working model, decision-making processes, and PBR projects. These were recorded initially by committee members and an administrative assistant, and were then supplemented by my own notes. Once the risk project was initiated these records included the progress, problems and decisions made in planning, design and implementation. Another source was the many documents issued by the committee over the years, including goal statements, mission statements, memoranda, presentation outlines, reports, and so on.

Project workgroup notes.

The risk project was designed and developed by the MHP research committee and through smaller working groups. Together these groups developed one assessment tool for adolescent clients - the AdQuest, and the family assessment questionnaire - the FamQuest. Records from meetings of these groups were key sources of information. An administrative assistant assigned to the project kept formal minutes. Each draft of the instruments was kept along with notations regarding any changes made, so that their evolution was well documented.

Focus groups, in-service training meetings and staff meetings.

As I will describe in Chapter VI, the initiation of the research committee, late in 1994, followed from a formal process of needs assessment conducted by a small group of MHP staff. This needs-assessment was a survey of staff regarding research - levels of knowledge and interest, training and support needs, and potential areas of interest - conducted by a preliminary research workgroup that I had formed to explore the potential for PBR. In addition, after the MHP research committee was formed committee members ran several focus groups with practitioners early in 1995. The purpose was to explore practitioners' attitudes toward research involvement, their views of what levels of support and assistance they might need if they were to participate in research, and potential practice problems that might be considered for study. Over the following years focus group methodology was used to assess plans for other research committee processes and to test the risk project instruments. Staff meetings and in-service training sessions were also key aspects of risk project planning and implementation. Careful notes were maintained and preserved from these focus group efforts, and from any "official" meetings that took place in regard to the risk project. These served as key information sources for this study and provided me with independent data sources to supplement direct observation. In addition to providing a rich source of information, particularly regarding the period before I had decided to conduct this study and was keeping a log, these sources also served to minimize the influence of my own, participant-observer's biases.

The project log.

In March 1998, a year and a half after the risk project was initiated, I began consideration of this dissertation study, and started to maintain a log documenting the development of the risk project and organizational processes that appeared related to it. This included my own reflections on any issues that I encountered in my work that might remotely relate to the risk project. The log contains reflections upon phenomena that came to my attention in my daily function as the MHP Director. I also kept careful notes in research committee meetings and in meetings related to the implementation of the risk project. I included formal feedback - from staff meetings, supervisory groups that I ran, issues discussed with supervisory and direct practice staff - as well as informal feedback. As a participant observer I was aware of the complexities of my role as an actor in the events I investigated and my role as a subject. In my log I distinguished between observations and my feelings and interpretations of events. I also sought the opinions and interpretations of colleagues and included them.

Preliminary studies.

As I will describe in Chapter V, several unpublished, small-scale qualitative, exploratory studies were conducted between 1991 and 1997. These included efforts to understand practice problems encountered by direct service staff, the staff experience of utilization and termination, and the study of responses to a short-term treatment pilot. These studies served as data sources related to formative influences on the research committee and the risk project. I refer to them in detail, and describe their specific influence in Chapter VI.

Formal feedback from adolescents.

Zaslow, and Takanishi (1993) note that adolescents' perspectives on the content and methodology of research on adolescent risk have been overlooked, yet are required if we are truly to understand the meaning of their behaviors. As the risk project evolved and the contextual assessment instruments were developed, feedback from adolescents was considered essential to shaping these instruments. The AdQuest was reviewed by an adolescent focus group and by long-term adolescent clients. Reports from these processes were a key information source.

Quantitative data from the risk study.

The risk project generated aggregate, quantitative data about adolescent clients and their families. These data are not the focus of this dissertation study, and I will refer to them only minimally when they pertain to the impact of the project on the organization. For example, I will refer to them when addressing the question as to whether the project generated useful information about client risks, how these data compared to existing practice wisdom within the AC, and what meanings were ascribed to these data by practitioners.

Additional data sources.

Information was also drawn from many additional sources. As a participant-observer, my own notes from the many meetings that I attended or ran - group supervision, interdisciplinary treatment planning meetings and MHP Operational

Management meetings - were an information source. These also included the formal debriefings of staff, supervisors and team leaders held throughout the implementation of the risk project. Data related to the project and its impact on practice also emerged through other formal organizational structures such as supervision, treatment planning and review teams, and staff meetings. Team leaders, who ran the program's treatment planning teams, and other senior staff met with me in a weekly MHP Operational Management group as part of our routine, everyday work. In many of these, formal minutes were kept and my own research log also included my reflections on organizational processes that appeared related to the risk project.

Due to my managerial position at the AC, I was involved in the creation of many reports and documents used in this account, and access to others that I have drawn on. These included grant reports on program activities, client profiles, service levels, and obstacles encountered in the everyday work. I also had access to Social Work Department and Adolescent Medicine Divisional reports. These included focus group reports on professional issues facing social workers in the Medical Center, and funding and financial reports. Finally, I had access to my own experience as a senior manager, within both the AC and the Social Work Department, managing during a period of significant reorganization, growth, and turmoil. Obviously, this experience was highly influential in shaping the perspectives that I present here.

Analytic Methodology

The design and implementation of the project are presented in the form of a retrospective memoir using an exploratory and descriptive approach. The process-based, narrative nature of the project dictated that I address two preliminary problems. First, how should I give structure to co-occurring, interwoven, historical processes data as they unfolded over time. Second what method should I use to interpret the meanings of these processes.

Tripodi, Fellin and Epstein's (1978) DSPE model, which I described earlier, provided a temporal framework to help address the issue of how to structure complex historical processes. Although Tripodi and his colleagues describe differential considerations that should be applied in advance of development and evaluation at each stage, the risk project was not a highly planned effort. Nevertheless, I find it useful to use the DSPE model retrospectively in my analysis.

The second problem is more difficult. What method should I use to understand and interpret highly fluid, interrelated processes within which cause and effect cannot be carefully distinguished, and within which my own decision-making role played an integral part? As I described in Chapter III, Argyris and Schon's (1992) methodology for organizational analysis suggests that the key analytical task is the iteration of the interplay between practice theories that are seen to be operating in the organization. They recommend the following steps. First, the investigator should identify official practice theories, such as formal descriptions of the organization's goals and the means used to reach those goals. These should then be compared with the different theories-in-use, i.e., the unofficial practices, theories, ideologies, and factors that make up the organizational culture that drive practices. Last, the investigator should evaluate where these many different official and unofficial theories and practices may be in conflict with one another or in congruence, and the impact of these dynamics on the organization.

Epstein(1995) provides an exemplar from clinical practice to describe how a reflective method might be applied using a single case methodology. Here the goal is for the practitioner to develop a method to examine his or her own premises and practices.

He describes the types of questions that might be asked when using reflective method. These focus on identifying central theoretical assumptions and "guiding metaphors"and examining where they conflict with one another or with observed phenomena. The reflective investigator might also ask, do there seem to be significant phenomena - such as activities, feelings, and issues - which remain unexpressed and, if so, how might they be brought forward?

In the investigation of organizational processes, Yin (1989) has advised that in studies of organizational processes propositions are rarely stated up front but must be derived from the assumptions that guide behavior or decisions. Following these heuristics, I derived the following questions to guide the investigation and to be applied to each phase of its development.

(1) What were the central, explicit assumptions, propositions, theories and guiding metaphors that shaped the project? And, what were the implicit, theories-in-use?

(2) How did these assumptions, propositions and metaphors arise? What was the process?

(3) What was the fit among the "official," explicit assumptions, the theoretical abstractions, and the observed or deduced "theories-in-action" implicitly driving the project? Were there any major contradictions between simultaneously held assumptions and theoretical abstractions?

(4) Which practice metaphors and theoretical abstractions are ignored or discarded in the organizational practice? How? And Why?

(5) Are significant phenomena (activities, feelings, issues) unexpressed and, if so, how might they be brought forward theoretically and/or metaphorically?

(6) What the investigator's deductions regarding the play between explicit and implicit assumptions tell us about the organizational culture?

(7) How attuned were the project's goals, methodologies and development to this culture?

(8) How do the identified explicit and implicit assumptions, metaphors and theories relate to each area of practice: clinical practice, management practice, and research? In particular, what are the theories-in-use that emerge in each area?

(9) Where do they conflict and where do they complement one another? How does this affect organizational goals? How do clinical practice, management practice, and research interact and do they create new learning and new activities or do they form impediments to action and learning? What organizational tensions emerge? Are these tensions addressed and if so, how?

The Reflective Practitioner as a Participant Observer: The Limitations and Benefits of this Methodology

In this study direct observation was the primary method of data collection, along with reviews of agency records, reports and other official and unofficial documents. My position of intimacy with the events that I study, as both a participant-observer and a subject, is very different from the observer-researcher role that Yin (1989) pictured. Although he recognized that the observer ultimately might come to participate in the phenomenon he was investigating, Yin imagined the observer as an outsider to events. However, the role of the investigator as both subject and observer is embedded in Schon's (1983) paradigm of the reflective practitioner (Grinnell, 1997).

In his book, The reflective practitioner: How professionals think in action, Schon (1983) does not explicitly address the issue of participant observation and - as far as can be ascertained - he was not a direct participant in the reflective processes he described. Nevertheless, participant observation is implicit in the reflective practice paradigm. The reflective practitioner uses his own experience and knowledge to make sense of problematic situations. Though Schon likens reflective practice to a process of continuous hypotheses testing, use of self allows the practitioner-investigator to derive analogues drawn from his own experience. This model epitomizes participant observation from the point of view of an investigator who is intimately involved in the phenomenon that he is investigating.

Though this level of participant observation may seem unusual in a case studies, it is not unique. It has been used in case studies of social policy processes (Rein, 1985), innovation in agency and service design (Fizdale, 1974; Morgan, 1990), community organizing (Weissman, 1966), and interactions within an interdisciplinary team in a health setting (Reiser, 1981; Sands, 1990; 1994).

Grinnell (1997) views participant observation as a valuable research method when:

> [the] research question is concerned with human meanings and interactions viewed from the insider's perspective . . . [when] the phenomenon is observable within an everyday setting or situation . . . [and when] gaining access is not a problem (p. 371).

This case study meets those criteria. It is concerned with the meanings of the events in the form of the experiences of "everyday" agency practice described from the point of view a management practitioner.

My access to information was both circumscribed and enhanced by my position as a manager but, on balance, the benefits outweighed the limitations. Access to some informal organizational processes and to some individual viewpoints - the concerns of some practitioners and their views on events and practices - may have been limited by my role as the director of the services. There are undoubtedly perspectives to which I will never have access. Alternatively, by leading the organizational development efforts described in this study, I had access to information that was not available to others yet was essential to it. I was an "ultimate insider." I had access to formal and informal documents and reports and to managerial decision-making processes that occurred in many different organizational subsystems at several levels. More importantly, as one "subject" of the study I had unique access to my own experiences and, as managerial decision-making is a main theme of this study, this was invaluable.

This method has its perils. How reliable are the data and what bias is there in observations made by an investigator so intensely involved in the events being observed? Another problem, inherent in the reflective practice method, is that the practitioner - in the isolation of his own reflection - may not be aware of the theories in action that he uses to interpret events. This may blind him to certain phenomena. His isolation may cause him to act on the basis of a distorted interpretation of events, compounding his interpretive mistakes.

Patton (1990) suggests that influence of the participant-observer's biases can be minimized by utilizing independent data sources to supplement direct observation. This study utilized a range of sources, including detailed notes of committee processes, staff meetings and focus groups, that had been recorded by several other participants in the research committee.

Grinnel (1997) also identifies several other ways by which the perils of participant observation can be minimized. These include the maintenance of a research log, the use of an advisor or supervisor, and the mobilization of colleagues for support and reference, all of which can enhance the willingness of the investigator to revise and let go of assumptions. These means were all available to me and I used them. I maintained a research log in which I carefully distinguished between my direct observations, my experiences and my interpretations of events. I utilized frequent conversations with my dissertation supervisor, Irwin Epstein, for reflection. This reflection was enriched by the fact that he was a participant in many of the processes I describe and, as such, had his own perspectives on them.

My reflection was not conducted in isolation in the course of intensely busy and highly interactive practice. This is one of the strengths of this dissertation. I utilized my colleagues to ensure that I revised and discarded assumptions and interpretations that no longer fit changing circumstances. Because I was not an isolated actor in events, I was able to share openly my reflections and thoughts with colleagues in the research committee and in both the AC and MHP management group. Throughout the project, as my dissertation study took shape, I informed and updated colleagues about it and compared my interpretations of events with theirs. I did this with individuals informally, and in research committee meetings and staff meetings as the project went forward. I actively sought other perspectives on my "discoveries" and I incorporated the lessons learned in my everyday work. The investigative processes that this dissertation study involved made my management style and decisions more consciously transparent to staff than would have been the case otherwise. I incorporated what I was learning in my ongoing work, so that this was truly a reflective process. In this process of reflection-in-action, the constant interaction with others, and between ideas, provided me with diverse perspectives on events and resulted in a constant reexamination of my own assumptions.

As a precaution, in my research log, I was careful in to distinguish between my observations of events, my feelings and my reflections. I was careful to ensure that differing interpretations were included in my narrative, and to make clear which are my own unique perspectives and which were the opinions of others. In the narrative I distinguish between interpretations of events that occurred simultaneously with these events and interpretations that were made in hindsight. By iterating these changes in my viewpoint, I lay bare the naming and framing process that I used. In this way the reader will be clear as to the nature of my own reflection-in-action and will be free to develop alternative interpretations of events.

Participant-observation had advantages over other methods in certain conditions. Patton (1990) identifies one unique strength of the participant-observer methodology as its particular utility in the exploration of the meaning of "ordinary" events. He reminds us that anthropologists are increasingly applying participant-observer methods, not only in the study of very different cultures from their own but, for the study of contemporary society. Patton suggests that participant observation is often the best approach, in phenomenological studies “when there is a methodological mandate to experience the phenomena being investigated” (1990, p. 72). Furthermore, he suggests the “participant-observer can also discover things that no one else has ever paid attention to” (p. 204). These were among the strengths of this study, in that it offered a practitioner perspective on neglected aspects of the research-practice debate. In particular, as I will show in the next chapters, the insider perspective drew attention to the fact that practitioners may be much more open to integrating research findings into their practice than has been described in the literature. Furthermore, it also highlighted the fact that practitioners’ need for flexibility and ambiguity in assessment and engagement of adolescent clients might be threatened by the introduction of formalized and standardized assessment methodologies. This aspect of practice has been overlooked, even in the PBR literature.

These experiences support the perspective that participant-observer research, such that undertaken here, can contribute greatly to the types of research methods that RBP proponents would consider more rigorous. Exploration of the phenomenology of agency practice can encourage active, theoretical debates about core issues. Preskill and Caracelli (1997), argue that, what they call, “practitioner-centered action research” (p. 209), has its place in the current range of organizational evaluation methods. They suggest that the field of organizational evaluation can only be strengthened by the use of many diverse methodologies including participant-observer approaches. They support this by, quoting Cook (1997) who said that ”without active theoretical debates about core issues in evaluation that transcend method, the field may not grow, even if it does not atrophy”(p. 47).

There is also value in the participant-observer method as an exemplar of ways in which managers can enhance their practice. Managers routinely engage in the kinds of activities that I describe here in order to make decisions, to innovate, and to evaluate programs and services. Our everyday work is partly based on our experiences, thoughts, feelings, theories, perspectives and biases, all in interaction with those of others with whom we work. The questions as to how complete and representative is the information to which I had access is one with which all managers must cope daily. Gummeson (1991) uses the metaphor of an "iceberg" to describe this phenomenon. However, he argues that managers should pursue the difficult role of participant-observer-researcher precisely because it can help reduce their dependence on secondary information, to improve their access to primary sources of information, and enhance their everyday work.

This dissertation study offers a methodology by which managers can reflect on and evaluate their practice. Consideration of the "theories" that may drive the behavior of subsystems within an organization and the evaluation of how these theories might interact with official goals and means has many analogues in the world of direct practice from which many social work managers came. The method should be familiar to them and therefore easily adapted to organizational life. I would also argue that "soft" evaluation conducted in the course of routine management practice is better than none.

Though it fails fully to meet the standards for prospective, organizational case-studies that Reid (1979) outlined, mention should be made of the case that can be made for retrospective studies, such as this. Historical methods, once common in social work dissertations, have become almost nonexistent, but they provide a legitimate way to build professional knowledge through the development of historical perspective (Fisher & Dybicz, 1999). Given the current turbulence in the practice environment, retrospective organizational case studies can build a body of literature that helps maintain the continuity of the social work profession's identity while documenting the changing practice context and evolving professional roles.

It is reasonable to conclude that reflective, retrospective, exploratory studies can provide exemplars of efforts to develop reflective organizational processes and a methodology for their analysis. There are too few examples in the social work literature and the creation of a body of work that attempts to lay open the practices of individual managers will hopefully provide the basis for further, new, more-rigorous self-evaluative techniques.

Chapter VI. The Pre-Rational Phase: The Background of the Risk Project in "Organizational Streams"

1. An Overview of the Chapter

In this chapter I will describe the development of the MHP research committee and factors that influenced the development of the risk project. These included efforts to improve the psychosocial assessment process, through team-based treatment planning and review, initiated in the early nineteen-nineties. However, there is no single line of development for the project. Lingering concerns about improving engagement and client retention and of risk assessment were expressed in many different areas throughout the decade. The research committee became the vehicle to shape these concerns and so its development becomes my starting point. The chapter is organized as follows.

In section two I begin by discussing the changing organizational context for social work research within the Medical Center from the beginning of the decade until the present. In section three I narrow my focus to the development of social work research activities within the AC from 1990 until the creation of the research committee in the fall of 1994. Section four gives an account of the development of the research committee in its first two years and describes the projects it developed. Section five describes program development efforts, not directly related to the research committee effort, that contributed to the development of the risk project. These include the development of treatment planning teams and the evolution of teams as a basic management structure, the creation of a decentralized, group-based supervisory structure, and the developments of new programs that led to the need for a better identification of high risk clients.

Section six concludes the chapter with an iteration of the explicit assumptions that formed the basis for the research committee and its mode of working from 1994 to 1998, when these assumptions came into question. I compare these with the implicit assumptions that were operating during the first two years of research committee development. Figures 1a & 1b (pages 87 and 88) show time-lines for the events that I will be describing in this dissertation as a whole. Figure 2 (page 89) shows the time-line for the development of the research committee from 1990 to 1996.

Figure 1a: Timelines for the Case Study

1990 to 1996

☐ 1990

THE PRE-RATIONAL PHASE

◇ The Brief treatment study is initiated with implementation of a time limited treatment model

◇ The time limited treatment ends after a pilot with 50 cases, data analysis continues another year

☐ 1991

◇ Qualitative study of practitioners' responses to innovation

◇ Qualitative study of practitioners' adolescent utilization patterns & "premature" termination

☐ 1992

◇ Creation of new HIV mental health services

◇ AC managers explore research development with a RBP consultant, but after 6 months discontinue

  ○ RBP is seen as alien to AC's current needs & "interpersonal" culture

☐ 1993

◇ Begin implementation of treatment planning & review "team model"

◇ New social work services developed-in AC's Medical & Reproductive Health Services(MRHS)

☐ 1994

◇ MHP research committee initiated, using PBR model

  ○ Committee conducts staff focus groups to assess research potential

◇ Exploration of "group model" for clinical supervision

☐ 1995

◇ Research committee projects initiated

  ○ Latino immigrant study

  ○ Loss survey

◇ More formal program management initiated through formation of an "Operational Management Group"

☐ 1996

Figure 1B: Timelines for the Case Study

1996 to 1999

☐ 1996

INITIATION

- ◇ The research committee undertakes a broad project: initially called "the MHP database study"
  - ○ Initial goals have programmatic & research focus
- ◇ The Risk Project is initiated:
  - ○ Goals become focused on assessment & engagement processes

☐ 1997

- ◇ RAIs & other existing instruments are considered and rejected in favor of an indigenous, contextual approach
- ◇ A risk inventory is developed
- ◇ The AdQuest is drafted

CONTACT

☐ 1998

- ◇ AdQuest is tested with clients
  - ○ AdQuest focus groups
  - ○ AdQuest is "tested" with long-term clients
- ◇ AdQuest is introduced to the MHP staff
  - ○ March '98, focus is on AdQuest's research potential
  - ○ April '98, focus on concern about clients - not practitioners & practice
- ◇ The FamQuest is designed
- ◇ Conflicts emerge within the research committee
  - ○ concerns over its effectiveness
  - ○ tensions over resource allocation

☐ 1999

IMPLEMENTATION

- ◇ Risk Project is "piloted" in one MHP team by five practitioners
- ◇ Research committee re-evaluates its model & programmatic role
- ◇ Risk Project implemention in all three MHP teams
- ◇ Research committee planning & restructuring
  - ○ Committee expanded and formed into project-focused workgoups
  - ○ initiation of design for an MHP ClinicalInformation System
  - ○ Formal integration of committee with other MHP activities

☐ 2000

Figure 2: Timelines for Pre-Rational Phase

The Formation of the Research Committee 1993 to 1997

☐ 1993

THE PRE-RATIONAL PHASE

◇ Exploration: The formation of a research workgroup
  ○ Staff survey re: attitudes to, & interest in, research

◇ Exploration: The formation of a research workgroup
  ○ Staff needs assessment survey re:
    attitudes to, & interest in, research

☐ 1994

◇ MHP research committee formed

◇ Research committee conducts focus groups with MHP practitioners to identify possible PBR initiatives

◇ Latino immigrant project initiated

☐ 1995

◇ Research committee develops "non-expert mentoring "model
  ○ goal to develop many PBR projects
  ○ goal to foster research participation widely in MHP

◇ Loss survey initiated

◇ PBR consultant joins research committee effort

◇ Patient satisfaction survey

◇ Termination from treatment study: preliminary work

◇ Use of existing data discussed

☐ 1996

◇ Exposure to violence and its impact study initiated

◇ MHP "Database" discussed
  For the first time the committee considers a broad-based, large-scale project that will
  ○ Involve the whole committee in a unified effort
  ○ Affect the overall MHP

☐ 1997

2. Social Worker Research and the Medical Center:

1990 to 1998

Throughout its history the social work profession has been intertwined with organizational life and professional practice has been influenced by organizational constraints (Weissman, Epstein & Savage, 1983). In host settings, such as health services, social workers are usually a very small minority and their work is generally not perceived to be a core service. In these circumstances, social workers must accommodate and adapt to the mission and objectives of the larger organization (Jansson & Simmons, 1986).

Research was a core activity throughout the Medical Center. It was a highly valued source of funding, prestige and legitimacy. The Social Work Department's mission was a microcosm of the larger institution's and one of its valued activities was the enhancement of professional activity through research. From the nineteen-fifties onward, a rich history of involvement in research led to an array of publications by Medical Center social workers (Rehr et al., 1999). At the start of the nineteen-nineties this department was poised to continue its professional leadership through research and knowledge dissemination. However, by 1994 changes in the organizational environment led to several new constraints that affected these activities.

In 1989, following more than a decade of service expansion and increased prestige and institutional visibility, the Social Work Department hired Irwin Epstein, a PBR expert, as its research consultant. The intention was to increase social work research activities. That same year its Director formed a research advisory group consisting of its senior management staff and faculty. Some consultants and social workers who were members of the Medical School faculty were involved in this group. Social workers were leading several PBR studies and were also participating in interdisciplinary research studies. Many were involved in teaching and training activities. By 1993 social worker research had become formally recognized as an important contributing factor to advancement for direct service workers. This was achieved through an initiative called the clinical career path.

The purpose of the clinical career path was to reward direct service practitioners as they became more experienced, advanced their clinical skills and expanded their service roles. A five-tiered classification provided for incremental salary increases. While qualification for advancement was tied to years of work experience, promotions were to be driven by a merit-based application process. An expectation of widening professional participation - program development, research involvement, supervision and teaching - was linked to advancement to higher, better-paid levels of the clinical career path. At the time the career path provided a potential incentive for research involvement and an additional reason why, in my capacity as a social work senior manager, I wanted to create opportunities for AC social work practitioners to participate.

Beginning in 1994, and with gathering momentum in subsequent years, the environment became less conducive to participation in research by practitioners. The spate of cost cutting and reorganization seen in health care across the nation (Hudson & Devito, 1993; Kopito et al., 1995) was mirrored in the Medical Center and its social work services. Downsizing and re-engineering became a management focus while simultaneous reorganization decreased the influence of core professional departments over the activities of their members. During this period social work managers had to turn ever more to the business of survival and reorganization.

Social worker research activities became less visible as other concerns gained the foreground as they were not viewed as essential activities by the Medical Center managers to whom the Social Work Department reported. While studies showing positive outcomes - especially as to cost reduction or revenue generation - were eagerly welcomed, social worker involvement in research was viewed as a drain on productivity. Ever tightening budgets forced staffing levels to be justified in terms of productivity or reduced operating costs (Blumenfield, 1995; Woodrow & Ginsberg, 1997).

Resources for research support were more scarce. Budget cuts forced drastic reductions in consultant time - to less than 25% of the 1990 level - affecting research consultants and others. Social work senior managers, many of whom had been active in developing research projects, increasingly found their time consumed by administrative tasks (27).

It is unclear how great an incentive the career path remained for research involvement by direct service workers in the three years after its inception. Two factors that might make research participation seem unnecessary for professional advancement must be considered. First, at the inception of the career path, workers were assigned to a level by virtue of years of experience. Research and program development were not prerequisites. Second, as time went on many staff continued to advance without research participation. Lack of pay increases during four of the five years from 1993 to 1998, meant that the career path approach was one of the only ways for the Social Work Department to raise salaries. It is possible that professional advancement became a less rigorous process than had been intended when the career path was developed, thereby reducing the perception among direct practitioners that engagement in research was a prerequisite.

Social workers who remained motivated to conduct research faced obstacles. Research mentorship was now more scarce due to a reduction in managers and supervisory staff. Decentralization had greatly loosened the tight-knit, formal supervisory structure that had helped maintain social worker involvement in teaching and research.

Focus groups, conducted with all Social Work Department personnel in 1998, documented the impact of this period of retrenchment on social workers. Gradual but significant reduction of the number of supervisory staff and a perception of fewer opportunities, both internally and externally, contributed to the feeling among direct service practitioners that there were fewer opportunities for advancement or professional self expression. Research involvement was widely viewed by many social workers - managers and direct service staff - as a casualty of these conditions (27).

3. Social Worker Research at the Adolescent Center:
1990 to 1995

The first formally recognized social work research project at the AC was a "brief treatment study," developed between 1990 and 1991. A group of five practitioners developed a time-limited treatment model, involved their colleagues in implementing it, and studied this implementation with fifty treatment cases. In the previous twenty-five years of the AC's existence social workers had little participation in research and had not initiated any studies of their own. One goal of the brief treatment study was to develop research among social work practitioners.

Between 1991 and 1995 no collaborative projects were developed by social workers. Two direct practitioners participated in physician-led projects. One, a study of adolescent contraceptive practices was never completed. The second was a comprehensive study of adolescent victims of sexual abuse that resulted in two peer-reviewed publications. Individual practitioners conducted small-scale explorative studies as part of their doctoral work, neither of which received a great deal of visibility at the time. However, these two unpublished studies influenced program development quite significantly later, so I will return to them after describing the brief treatment project and its impact.

The brief-treatment study: 1990 - 1991.

The "Brief-Treatment Study" was a study of a time-limited psychotherapy model. That it was initiated in 1990 is doubly remarkable because, although this was a period of optimism about research for the Social Work Department, for AC social workers this was a period of insecurity. The continued existence of the AC was being debated by Medical Center senior management and its leadership positions had been held vacant for almost a year.

The study grew out of the efforts of a social work manager, temporarily covering the AC, and five practitioners. Both the time-limited intervention model and its evaluation were driven by practitioners' concerns about rates of dropout from treatment. The covering manager, a member of the Social Work Department's research advisory group, worked with social workers to shape their concerns into a viable study. Research was embraced, at least by the five group members, as a tool to address long-standing practice concerns.

The study was conducted over a seven-month period, and work continued for a year more as the project group analyzed the data and formulated the findings. There are several significant aspects to the development of this study. It was driven by practice concerns and designed by practitioners and it was the first MHP study to experiment with a particular approach and viewpoint, i.e., the use of research to evaluate a time-limited model of intervention. Though the study hypothesis, that a six-session "contract" would improve client retention, was not supported by the findings it produced other benefits. This was the first effort at the AC to gather clinical information regarding clients and their treatment rigorously and methodically, and it became an exemplar of practitioner-initiated research activity. It provided leadership for subsequent research development as one of its creators joined me in creating and leading the MHP research committee.

Upon its completion, the brief-treatment study had no immediate, direct impact on the MHP practice. One reason for this was the change of leadership for the MHP in October 1990 - when I was hired as Director - and to my identification of other, more urgent priorities for attention. These included addressing budgetary issues and establishing some structure in the extremely unstructured MHP, which lacked any process for assessment and treatment review. However the fact that the study had no immediate impact also reflects the fact that, not only was research not familiar to practitioners but, the practice culture of the MHP was not ready for treatment innovations that might affect everyday practices overall. However, the study did affect organizational practice in the longer term particularly in my efforts to create a more structured service environment. During the study, group supervision was used to monitor each client's ongoing treatment and to support practitioners' work with the goal-focused model. The existence of this forum drew attention to the need for structures for case review and clinical support.

Small scale qualitative studies of service innovation and termination: 1991-1992.

Two exploratory studies, which were individual projects completed as part of doctoral course work, also had an influence on program development and drew attention to the need for research activity linked to practice. The first of these two, which I conducted between 1991 and 1992, was an exploration of the impact of service innovation on direct service staff. Informed by Schon's (1983) theory that practitioners use exemplars derived from experience to give coherence to unfamiliar practice problems, it looked at the social workers' experiences with the brief treatment model.

The findings, (Peake, 1991) underlined the difficulties practitioners had in shifting gears from long-term, open-ended treatment to a time-limited, highly structured and goal-focused approach. All but one of the nine practitioners interviewed were confronted with practice dilemmas that they had a great deal of trouble resolving. For the first time they were faced with time constraints, the task of adapting their practice to a goal focused approach, and the pressure to prioritize complex problems into concrete short-term objectives. As a result the practitioners felt that they were leaving gaps in their treatment - voids unfamiliar to a holistic approach. They felt that they were not demonstrating the empathy and patience to respond to all of their clients' concerns. They found few analogous experiences to guide them and experienced a great deal of self-doubt in those situations. Lack of opportunities to learn from one another, and an organizational culture that did not encourage sharing of difficulties, contributed to this experience. These findings reinforced my decision to make development of a treatment review structure and support groups a priority, a decision prompted in part by the experience of the brief treatment study.

The second qualitative study, completed in 1992 by a practitioner who had been a driving force in the brief-treatment study group, examined practitioners' perceptions of client utilization patterns (Mirabito, 1997). It identified the difficulty many practitioners had in coping with clients' short-term utilization patterns, and what they viewed was premature and unplanned termination by clients. It too drew attention to the need for opportunities for practitioners to reflect jointly on practice problems.

What was learned from these two modest, small-scale exploratory studies that influenced the formation of the research committee and risk project? Both studies used interviews with staff to learn about program development needs. The second study, in particular, suggested that direct service staff found clients' short-term and unpredictable utilization patterns to be disturbing. Both studies drew my attention to the usefulness of small-scale, "quick and dirty" organizational studies for identifying management priorities derived from practice problems. They suggested that encouraging additional research efforts would be worthwhile. Both made a significant contribution to my own management agenda as, shortly afterwards, I began an effort to develop treatment planning and review teams and supervision groups. However, because this effort was the priority, research development received little administrative attention and was not a factor in overall planning for two more years.

4. The Formation of an MHP Research Committee: 1993 to 1995

The idea of encouraging practitioner research activities remained alive for me even though my attention to establishing the fiscal base and treatment review processes took precedent, until 1993. In that year the AC Director and I also began to explore ways in which we might encourage or initiate research for the AC overall. We explored available resources within the Medical Center and met with an RBP consultant provided to us by the Department of Community Medicine. However, in the face of severe constraints on the time available to us - made even more tight by our activist approach to grant writing, service development and business planning - we found the RBP approach to be overwhelming and impractical. Given that the AC had no track-record of research activity and medical and mental health practitioners had little research exposure - but a great deal of practice-wisdom - RBP did not fit well with our needs or the AC's organizational culture.

Only in 1999 did the Director and I initiate a formal AC research unit to support the range of training, research and academic activities that were needed for accreditation of the AC's Adolescent Medicine Fellowship Training Program. As I will describe in Chapter IX, this unit was not intended to develop RBP but to develop a wide range of research and evaluation strategies.

In the early nineteen-nineties the AC did not have the budgetary resources to support researchers. Lacking the funds to recruit a consultant of our choice, and concerned that AC research activities should be driven by practice considerations so as to fit well with the organizational culture, we decided not to continue working with the RBP consultant. Exploration of the issue of research development for the AC overall ended for the time being.

My own interest in developing MHP research activities continued to grow and, as it developed, so did my interest in the PBR approach. In 1993, I initiated a loose planning effort within the MHP to explore developing PBR. This lead to the formation of a research committee in the fall of 1994 and to the initiation of its first PBR projects in the spring of 1995. Next I will describe how this effort developed, as a direct service practitioner and I felt our way forward to form the MHP research committee, and the PBR projects that resulted from it.

Preliminary Explorations into Research Development

In the spring of 1993, I began to talk informally with the practitioner who had developed the study of practitioners' perspectives on client utilization regarding how to develop research within the MHP. This practitioner had been a key member of the brief treatment workgroup and, like me, was a doctoral student. Shortly afterwards we formed an exploratory workgroup with two other practitioners and a social work supervisor. Four of the five of us were doctoral students.

The task this workgroup outlined was to plan an approach to research development shaped by the assumption that most practitioners lacked basic knowledge of research and were probably averse to it. Most of the workgroup members were familiar with the literature identifying the gulf between research and practice and with the viewpoints of RBP and PBR, some of which I cited in Chapter III. Although all had participated in the brief treatment study, there was disagreement about its costs and benefits, and whether it had been too intensive an effort for the rewards it provided.

The concerns and purposes that some had in joining the discussions were to ensure that research did not damage clients or services, a position in regard to organizational innovation that Klein (1980) termed the "defender role." This position, in which the practitioner represents himself or herself as the conservator of practice values such as the client's right to self determination and quality of care, proved to represent a powerful ideological current within the organization. As I will show in later chapters, concern about clients often served as a metaphor to safeguard against any encroachment on practitioner autonomy and existing practice methods. At the time, this concern suggested to me that the assumption that research would not be well received reflected members' own concerns about, and experiences with, research. This was also to be a continuing theme when the research committee was formed and throughout its history.

To assess service staff interest and training needs, and identify potential research opportunities, a survey questionnaire was developed and circulated to social work staff in the fall of 1993. The survey showed that most direct service staff were wary of research, and felt they lacked skills and time to engage in it. It also identified a wide ranging, rather general list of potential topics, best described as a *potpourri* of ideas. These included surveying clients about their attitudes toward services, relationships with peers and friends, contraceptive practices, knowledge about sexually transmitted diseases, and attitudes toward pregnancy. Other suggestions included treatment outcome studies, comparisons of treatment approaches. The research work group was unable to identify widely shared research interests rooted in day-to-day practice problems. When two members of the committee left the agency the work of the group was stalled for half a year.

The Development of a Research Committee Model

In the spring of 1994, staff turnover and new grant funding for expansion led to the hiring of several new staff. In the summer of 1994 the group was reconstituted - with six members, four of them direct service workers, meeting weekly. Named the "MHP research committee," it defined its task as the development of social work research activities within the AC, but its formal structure and relationship to other MHP subunits was not defined. Between 1995 and 1998 the MHP was to create a formal administrative structure, with a core management group of four and an Operational Management group of nine. Still, in 1994 and 1995, even as it started to expand its funding and staffing, the MHP retained its small, informal administrative structure - a social work supervisor and I, who between us supervised almost all the practitioners and administered the program. As we were both in the committee, members gave little consideration to the committee's formal relationship to overall program administration and defined it as a "partnership between management and direct services staff." Its stated purpose was to involve practitioners in the development of research activities to enhance practice.

Fostering practitioner participation in PBR: a single project, or several?

The committee faced four major hurdles. First, staff were generally inexperienced with research and wary of it. Second, committee members themselves were hardly more experienced. Third, the committee had no access to outside resources for consultation and technical assistance. Fourth, both practitioners and managers maintained heavy workloads with no time allocated for research activity. Many practitioners had administrative responsibilities in addition to their clinical duties as I described in Chapter IV. Furthermore, staff turnover in the previous year meant that most of the direct service workers were new to the agency.

First the committee grappled with the development of a working model for itself. Should it work on a single research project, as the brief treatment study group had done between 1989 and 1990? Or should the committee try to develop several research projects at once? Eventually, it chose to try to develop several projects. Members assumed that immersing the whole committee in a single study might only isolate it and lessen its effectiveness in involving other staff in its projects. They developed a "formal" committee model in which members would serve as non-expert research mentors and work with interested staff groups to develop projects. This would be the mechanism for its integration with the overall practice. Given the lack of expertise on the committee this was ambitious, but members wanted to initiate staff interest and involvement.

How broadly to focus: the preference for small-scale projects.

A second discussion on how broadly the committee should it focus its research, led to the decision to develop small-scale projects, in part by design and in part by default. This question reemerged periodically and, as I discuss in Chapter XIII, it was a factor in the development of the risk project. Committee minutes from 1994 reflect three reasons for a focus on small-scale projects.

First, committee members saw a need to develop staff motivation for research and interest in it. The committee decided that small scale projects would generate "results" in the form of research findings and staff presentations most quickly. These rewards would enhance motivation and widen interest. Second, it was thought that small projects would require less overall staff buy-in and could be done by more motivated individuals or small groups. It did not want to place all its project "eggs" in one basket. Success would not depend on one, critical effort. Third, small scale studies might be the fastest way to generate consultant time that was paid for by the Social Work Department. Research consultation resources were being rationed very carefully and were only available for planned or ongoing studies. There was hesitancy about supporting the committee model, which was new and had yet to produce anything. Only when projects emerged from the committee, a year later, a nine-month commitment was given for Epstein to be available as a PBR consultant for one hour a month.

Where to focus: the identification and selection of practice problems.

Reviewing the staff survey of the previous year, the committee decided that this first effort had been too concerned with staff's comfort levels and, as a result, had not identified practical ideas, i.e., practice concerns around which interest in PBR could be developed. In October 1994 committee members conducted a series of small focus groups with all MHP practitioners to identify practice problems from which research might be developed.

The themes that emerged reflected concerns about the fit between client utilization and practitioners' perceptions of client-need. How could assessments of clients be enhanced to improve motivation and retention in services? What were client expectations? What had they been told about why they were referred? What were the consequences of noncompliance? What were their prior experiences of counseling and how might these experiences affect their attitude toward services? How could engagement processes be enhanced to improve retention in services? How could direct service staff better understand and handle clients' own views of their problems and how should clients' short term use of services be viewed? Should services be tailored to short-term utilization patterns?

Focus group responses showed two related yet opposite approaches to addressing practitioners' concerns about client utilization patterns. On the one hand there was a willingness to examine the service model to make a better fit with clients patterns. On the other hand there was a drive to change these patterns by increasing client motivations and interest by enhancing engagement strategies. This dilemma, in my view, characterizes the essential problem in serving adolescents that I discussed in Chapter IV.

The practitioners' responses also suggested the underlying belief that research could enhance the understanding of clients' problems, motivations and perceptions of help that clinical practice alone could not fully fathom. This belief does not seem typical of the attitudes that the literature reviewed in Chapter III suggests practitioners have toward research, i.e., that it is irrelevant to practice. It is difficult to know whether this apparent difference represented a shift in the MHP practitioners' attitudes or reflected the influence of the organizational culture of the Medical Center, which formally embraces research efforts. Another interpretation of this apparent anomaly between MHP practitioners and the field in general might be an effect of the focus-group process. This PBR process encouraged practitioners to discuss common practice problems with their colleagues and this, in turn, allowed them to consider the benefits of research.

The development of an informal "activist" approach.

In the spring of 1995 the committee briefly returned to the idea of a broad "planning study," to focus on key service delivery issues. Though the committee went as far as outlining potential next steps - the assessment of client needs, the creation of a user profile, conducting an analysis of the fit between services and users, and the use of assessment instruments - it did not pursue them. The committee returned to an effort to establish itself through much smaller-scale, practice-based projects. That some committee members were now initiating small scale studies added momentum to this choice of direction. Discussions of how to develop and maintain these types of studies dominated committee minutes for the next year.

Between fall 1994 and spring 1996 the committee's work was divided between developing PBR projects and a continued preoccupation with its own processes and its relationship to the overall program. The espoused model was one of non-expert mentoring. As they gained PBR skills, committee members were to work with those outside the group to develop projects. In actuality members were usually advocates not mentors. They served as activists whose task was to promote research interest and, when working with others outside the group, they carried the bulk of the research project work.

The Research Committee Projects: 1993 to 1995

In the committee's first two years six projects were initiated, five of which were later completed. Two of these were qualitative studies that were initiated before the committee had access to a consultant. I consulted to the first one, a practitioner-led qualitative study of the experiences of Latino adolescents who were recent immigrants.

The second study, also qualitative in nature, explored practitioners' experiences with adolescents' "premature" termination from treatment and was conducted by a practitioner who was enrolled in a social work doctoral program. I will describe each one shortly.

In the fall of 1995 a PBR consultant, Irwin Epstein, was made available for one hour monthly by the Social Work Department in response to my requests for support. His approach was considered highly congruent to the PBR approach that was evolving "naturally" within the committee and considerable enthusiasm was generated by his availability. Committee members now had access to expertise that they felt was sorely needed. At that time the committee had initiated one PBR project and several others were being discussed or initiated. I will briefly describe these projects and their significance to the risk project.

A qualitative study of Latino adolescent immigrants.

The first project, the "Latino Immigrant Project" was initiated late in 1994 by a practitioner who was developing services for recent immigrants. This qualitative study of eighteen adolescents was thoroughly integrated into the service - for example, assessment sessions served as research interviews. In turn, the interviews provided a rich source of information, a thematic analysis of which provided the basis for service planning and a curriculum-based therapeutic methodology. This methodology involved the creation of each participant's individual "story" by using the group session to develop a retrospective immigration diary for each member. By identifying clinical themes, in advance of the therapeutic group process, qualitative research methods thus enhanced the clinical. For committee members, this experience showed that integrating research methods directly into practice was, not only possible but also, potentially of direct benefit to practitioners.

A school-based survey: adolescents' experiences of loss.

The second project, "The Loss Survey" was initiated in 1995 by practitioners within the HIV program component of the MHP created in 1992 from grant funding. Its newly hired staff brought an activism to creating new services for HIV infected youth, and between 1992 and 1994 they developed a service model and accountability system. In 1994 funder mandates required that the HIV program staff begin to increase the client base of adolescents affected by HIV. This difficult task involved intensive outreach and aggressive case-finding.

The loss survey was led by an HIV program practitioner, also a research committee member, who advocated for PBR approaches to case-finding and service-building. Although it was primarily intended as a case-finding tool to identify clients with HIV-related loss, this needs-assessment survey of adolescents within three inner-city schools inquired about loss overall and about interest in services. Funding, through the HIV services grant, provided twelve hours of additional research consultant time for this project.

This survey did not prove to be an effective way to identify and recruit individual respondents directly into service. Nonetheless, it proved to be an effective program development strategy in that it enhanced the program's visibility. In addition, the loss survey, which effectively documented the extensive losses experienced by this population of adolescents, has resulted in several conference presentations and a paper describing its findings will soon be submitted to a peer-reviewed journal in the spring of 2000.

This project had great significance in the development of the risk project. Its findings (Yaverbaum, 1999) drew a powerful picture of the prevalence of non-HIV related loss and bereavement problems facing the MHP's general population and of the high levels of distress that adolescents experienced from these losses. Ninety-six percent of respondents reported having lost a family member or close friend and 73% reported that they "thought about these losses some, most or all of the time." Moreover, 38% of all respondents reported thinking about these losses "all or much of the time." Yet at the time, the MHP had no specific services in place to address non-HIV related losses. Furthermore, loss was not routinely explored during the assessment process. The study showed that instruments could effectively identify needs that might not be uncovered in a psychosocial assessment interview, in which the focus was on the presenting problem and the methodology was driven by interpersonal approaches.

A client satisfaction survey.

The third project was a marketing and client satisfaction survey initiated in August 1995 by myself and another manager. It was prompted by the AC's physical relocation in March of that same year, and concern about the effect of this move on clients' utilization of services. Fifty adolescents - making a medical visit - were surveyed regarding their knowledge of, use of, and satisfaction with services. This "quick and dirty" survey, completed within a four-month period, was used by the AC's management group to garner additional resources. It influenced the risk project in that it demonstrated the value of systematic study to resource development as its unrefined data used as part of a business plan had helped expand funding.

Using available data to study adolescent exposure to violence.

The fourth project was called "Exposure to Violence and its Impact." It was initiated in 1996 by two practitioners and a supervisor and utilized existing clinical information from the service in the form of health questionnaires completed by clients when they had their annual physical examination at one of the AC's school-based health centers. Study data was collected from these questionnaires on history of depression, suicidality, smoking, substance use, sexual activity, witnessing violence and victimization. Two committee members and another direct service worker participated.

The first presentation of this study's findings was made recently in a Medical Center forum (Hoffman & Diaz-Cruz, 2000). In contrast to the research literature, which generally disparages the use of available data (Epstein, 1997), for committee members this project illustrated the utility of available information in PBR. Simultaneously, the study highlighted the limitations and unevenness of the MHP's current service record, suggesting that a more standardized record would be useful for practice and management purposes. This study also influenced thinking about developing an MHP information system in that it convinced committee members that creating a solid foundation of available clinical information would be useful for developing new PBR studies.

Adolescents' termination from treatment.

Attention was also drawn to the need for enhancing the quality and availability of clinical information for the MHP, and the desirability of developing the service record as one method for this, by the fifth project - adolescent termination from mental health treatment. This project was a doctoral dissertation study that combined qualitative and quantitative methods to study adolescent termination patterns. It used both available information - through a survey of the service record - and client interviews. The study, was initiated in 1997, but preliminary work including discussion of the project in committee meetings and a review of available data was occurring in 1996. This study arose from the small-scale qualitative study of client utilization conducted in 1992, and built upon it.

Consideration of the issue of termination - and preliminary findings that suggested that most clients left treatment without much or any discussion with their therapists - implicitly raised the issue of engagement in services and how the initial "contract" might influence utilization and termination patterns. This helped lead to interest in developing the risk project - with its focus on assessment, engagement in treatment, and client expectations regarding services.

A proposed qualitative study that failed to materialize: HIV infected females' aspirations to motherhood.

A sixth study, initiated within HIV services in late in 1995, was called "Motivation for Pregnancy in HIV Positive Adolescent Females." It was based on anecdotal evidence from practitioners that suggested that female clients frequently became pregnant within the year following an HIV diagnosis. Plans were made for a qualitative, explorative study and one-time funding from the HIV services grant was used to make the PBR consultant available to this project group.

After almost a year of preliminary work this project was dropped. There appeared to be two reasons for this. First, many members of the HIV team were involved in the HIV loss survey described above, and may not have had the time and stamina to conduct two projects simultaneously. Second, tensions arose within the HIV team over "ownership" and leadership of this project. It was the brainchild of practitioners who were not involved in the research committee. They appeared to resent the committee structure that necessitated a committee member - the HIV team member who was leading the loss survey - as the project liaison. These tensions came to my attention through informal channels only in the spring of 1996, when they seemed to be blocking any movement on the study. Then my committee co-chair and I attempted to address them. At our urging the motivation for pregnancy in HIV infected females project group was invited to attend some committee meetings, bypassing the "official"committee model. Doing this was an indirect acknowledgment that the "mentoring" model was not working, and it was controversial within the committee. Some committee members felt that clearer lines should be drawn around the committee while others felt that the committee should be opened up.

This remained an underlying tension that was not resolved due to a general unwillingness to reconsider the committee model. What were the reasons for this? Practitioners in the committee, including my co-chair, were those most invested in maintaining its formal model and more "bureaucratic" functions. Managers, I included, were most interested in adapting the model and creating a more flexible committee structure.

In retrospect, I believe that I was unwilling to alienate the practitioners on the committee by loosening its structure as they, among all the MHP staff, were the ones most invested in research development. As I will describe in Chapter IX, similar issues arose again 1999. At this time some practitioners who had joined the committee early on, calling themselves "flagship members," expressed concerns that their investment and hard work might be diluted by the expansion of the research committee. The issue dropped from sight as the committee became more engaged in the risk project in 1996. When the motivation for pregnancy in HIV positive adolescent females study group had not progressed, by 1997, the committee decided to drop it.

A continued focus on small-scale studies.

Though periodically the committee considered whether to engage in projects of broader scope, and whether it should initiate a project that would involve the whole committee, small-scale studies remained its active project work. The mentoring -

advocacy approach proved extremely slow to develop projects and, apart from the loss survey, which utilized the efforts of four direct service staff, most projects were largely carried out by committee members. Despite tensions within the committee about the pace of research development it continued its efforts to foster projects that interested and engaged the service staff.

5. Non Research-Based Organizational Development Initiatives That Contributed to the Risk Project: 1991 - 1995

As a key player in the risk project development, my assumption when I began this study was that interest in the topic of risk originated in the research committee. As I examined organizational records, I was surprised to discover that discussions regarding how to enhance risk assessment practices arose in several other AC forums between 1991 and 1995. In this section I will describe practice concerns and program development efforts, arising between 1990 and 1995, that highlighted risk assessment. These were the development of a team-based treatment review process, the development of group-based supervision, and the development of new services.

Improving Assessment and Treatment Planning Within the MHP: The Team-Based Review Process

One aim of the risk project was to enhance the intake process. However the AC's psychosocial assessment methodology was not static, and non-research-based approaches had been undertaken to improve assessment, disposition and treatment planning between 1992 and 1995. This was done through formal development of treatment planning teams, revision of psychosocial assessment and treatment planning processes, and development of new practice standards.

In 1991 the MHP was staffed by approximately a dozen practitioners and a consulting psychiatrist. Almost exclusively, the modality available to clients was individual psychotherapy. Admission and treatment decisions were made by the practitioner who first met with the client during a single intake appointment. The model of services fit, most closely, a group private practice, with workers essentially selecting their own caseloads.

Development of a formal periodic review, in which individual practitioners presented cases to a psychiatrist and supervisor, was begun in 1992. In 1993, a team-based assessment and treatment review process was begun and the assessment process was extended from a single session interview to a three-session series. By 1994 decisions about admissions, case assignments and treatment were being made in one of three interdisciplinary review teams co-led by a senior practitioner and a psychiatrist. More uniform admission criteria and treatment planning standards were developed. Redesign of assessment forms and a more detailed treatment plan was complemented by a careful review of both short and long-term treatment goals in the team meetings.

By 1996, with the team structure firmly established, team leaders were participating in operational management, the forum for developing and planning services. By 1997 they were participating in the evaluation of staff performance. There were now four teams, three for the MHP and one for social work practitioners providing services within the medical services. By 1998 team leaders were developing professional competency guidelines, performance evaluation criteria, supervisory structures and so on.

Establishment of a team culture, combined with the hiring of a more diverse staff, led to widening discussion of family involvement in assessment. Broad planning decisions regarding patient care, which in the nineteen nineties had been made almost autonomously by individual workers were now subject to team review. There was considerable discussion in operations meetings about assessment standards. Team review and clearer standards meant that differences between individual practices also were more evident. The work of individual practitioners became more visible and public as they became more accountable to colleagues for decisions regarding patient care. Especially during the first two years, conflicts and tensions arose regarding fears of a loss of professional autonomy. Conversely, the development of teams created opportunities for some direct service staff - to serve as team leaders, supervisors, and teachers, and for participation in decision-making.

Group-Based Supervision

Between 1994 and 1997 a parallel effort was undertaken to develop group-based supervisory structures, partly in response to the two qualitative studies of practitioners experiences, described earlier. Experimentation was done with different supervision models and by 1996 all practitioners were participating in supervision groups led by me and the social work supervisor. Additionally, many individual supervisions were being conducted by the most experienced practitioners. Gradually, supervision was increasingly decentralized, conducted primarily through a "menu" of forums. Some individual workers were attending three different groups weekly in addition to their team meetings. Overall supervisory responsibility was shared by seven of the most experienced staff. These developments added to the visibility of practitioners' work, but also with so many practitioners conducting supervision, supervision became less centralized.

New Services Development

New services developed between 1992 and 1995 also contributed to the development of the risk project. I will describe the two most significant service developments that resulted in the rapid expansion of the MHP through the addition of eleven new practitioner positions. These efforts, funded by government grants, were the development of an HIV-focused mental health unit and the development of social work services devoted solely to the AC's medical practice.

Development of HIV-related mental health services.

New funding for HIV-related services was obtained in 1992 and expanded in 1994, and this created opportunities for service expansion and for experimentation with practitioners involvement in the design and maintenance of accountability and reporting systems. This new mental health program for HIV affected and infected adolescents provided ideas and momentum to both the research committee and the risk project. Staff hired for it were comfortable with a more aggressive method for assessing client risk and behaviors than was accepted practice within the MHP at the time. This was due, in part, to their need to be activists if they were successfully to build the program. The need to actively case-find and report to the funding source on their work with very high risk adolescents led them to take extensive risk histories very early in the engagement process. This required a very active, highly focused assessment process that targeted high risk behaviors specifically.

In its first five years, that is until 1998, practitioners from the HIV program were dispersed among the three assessment and treatment review teams. This was done to ensure that they were able to identify clients who were eligible for the HIV program's services, and to maintain communication and collaboration between the MHP overall and specialized services. In 1998, as a result of a change in funder requirements, the HIV program practitioners were reorganized into a separate and distinct team. However, their integration into the team structure during the mid-nineties meant that they were aware of the assessment practices of their colleagues. These practitioners brought a more activist approach to assessment and case finding, not unusual in HIV and AIDS services at that time. They were critical of the loose and uneven assessment practices of the MHP overall, and felt that more rigor and standardization would enhance services.

Two of the five practitioners recruited for the HIV program were among the first members of the research committee and a third became an interdisciplinary team leader. Despite a lack of research experience, they had developed the loss survey and were highly active in the future development of the risk project.

Primary care social work services: 1993.

In 1966, when the AC was founded there was no distinct MHP. Mental health service provision was one function of the social worker in the interdisciplinary medical team. As the MHP program grew and became defined as a counseling and psychotherapy program, its more specialized services resulted in a lack of social work provision within the AC's medical services. By the late nineteen-eighties the MHP had become a separate subunit of the AC, accounting for more than 45% of its annual visits. As a result, social work services were only available to those clients receiving medical and reproductive health services (MRHS) only by referral services to the MHP or on an emergency basis. With few services available on demand, these adolescents were rarely engaged in ongoing MHP services, and in 1991 they faced a waiting period of four weeks post-referral.

In 1993 grant funds were obtained to develop social work services specifically for clients receiving services in the MRHS. Two practitioners were hired in the fall of 1993 to work as part of the primary care program, and a third, fourth and fifth were added in 1996, 1997 and 1998. For this new MRHS social work service the problems of who should be served, and how to serve them, came to the forefront. Due to the large volume of medical service visits, 18,000 in 1995, MRHS social work practitioners were working within a physician-driven referral system and faced competing demands to be available on request and to develop ongoing services.

A small group of supervisors and practitioners, two of whom were research committee members, was convened to plan social work services for the MRHS. In 1995 the first documented discussion of using a PBR approach to risk assessment and service design occurred in this group. The following practice concerns were identified: (1) Physician referrals were idiosyncratic: was there a better method to assess service need? (2) A "social work on demand" system led to contradictory expectations - these practitioners had to be constantly available yet were expected to offer ongoing services. (3) Many adolescents did not understand why they were referred for social work services, and they often arrived at practitioners' doors resentful. Most important, the practitioners stated "most referrals don't work out."

Without a profile of client needs, the MRHS work group was concerned about how to plan services in a large program area with relatively undifferentiated needs. These social workers were unsure that those most at risk were being served. Could they better identify priorities by developing a taxonomy of client groups by risk? The primary care work group considered several ways of doing this in including key informant survey tools - for clients, referral agencies and parents - and using available data. The consideration of these PBR approaches to program development was abandoned, under pressure to act quickly, and the group refocused on small scale program enhancements such as services for readily identifiable patient groups - such as adolescent parents.

An opportunity to use research methods to enhance service development methods may have been missed, but the constraints on the MRHS social work group made it difficult to succeed. The pressure to produce results quickly did not fit well with the slow pace of the research committee's work that was necessitated by the need for practitioners to develop PBR skills. The research committee was reluctant to make an effort in an area of the program where circumstances were difficult to control. While the MRHS workgroup did not produce a practice-based study, its work was utilized later when the research committee began to consider the risk project.

The MHP Managers' Need for Information on Adolescent Risks

The experience with the formation of the HIV program drew my attention, and that of the program's social work supervisor to the fact that accountability and reporting systems for other programs were poorly designed, as they were loosely integrated with the clinical service, and required extensive review of service records. In contrast, it demonstrated the usefulness of well documented clinical information in impressing funders. Other developments reinforced this view. During 1995 and 1996, chart surveys had to be initiated to develop profiles of adolescent clients and their risk factors to meet funding requirements for the MHP's program's largest grant-funded component. The laboriousness of this process drew attention to the need for a more efficient method to collect and report information. The termination study, which relied on data gathered from the service record, also exposed the considerable variation in the quantity and quality of available information revealed during the clinical assessment process.

As a response, discussions in MHP operational management meetings focused on the development of a system to collect information for reports that could be integrated into the activities of the treatment planning teams. Preliminary efforts by the team leaders to develop such as system were not successful due to difficulty in integrating the reporting requirements of several different grant funders. This effort was set aside once implementation of the risk project was planned.

6. An Analysis of the Pre-Rational Phase

Many organizational streams contributed to the formation of the risk project. Chief among them were longstanding concerns about lack of client engagement. The challenges that ensued from program expansion into new services brought interest in new approaches to assessment. They also illustrated the need for easily accessible, well-presented clinical information regarding clients and their families. The HIV program staff's activist approach also greatly contributed to the new idea that assessment practices could be more rigorous and could be enhanced by using formal instruments.

However, the risk project also had a foundation in the decade-long effort to improve assessment and treatment review through the development of teams, which made practices more transparent than they had been and added impetus to continued improvement efforts. These contributory factors were not enough, in themselves, to create an effort to address engagement and assessment practices. These issues needed a vehicle that would encourage their exploration and iteration and that would lead to a plan for action. The research committee was able to create that capacity, but only once it was established enough to develop a link between "clinical" and "program management" viewpoints.

In Chapter V, I described how Schon (1983) conceptualized the "naming and framing" process by which practitioners map and contain troubling, loosely defined, highly uncertain situations so as to compose a workable problem. In this process by which reflective practitioners construct the "reality" of the situation, Schon says:

> [They must] determine the features to which they will attend, the order they will attempt to impose on the situation, and the directions in which they will try to change it. In this process they identify both the ends to be sought and the means to be employed. In the ensuing inquiry, action on the situation is integral with deciding and problem solving is part of the larger experiment of problem setting (p 165).

How did the practitioners who fashioned the research committee frame the situation they faced as they aspired to develop practitioner research, and how did this affect their approach? First, they believed that practitioners should control and shape research development and determine the problems that research should address. Simultaneously, the same apprehensions about research that made them want to shape the MHP research effort, made them lean toward informal and unassuming approaches toward doing so. PBR offered a means to develop both the committee members' comfort and skills and the interest of their colleagues.

The committee also framed the situation they face as one in which they were motivated "insiders." Despite the canonical position of the Social Work Department that research was highly valued, this department was not in position to offer much support to them. In 1994 and 1995 its budgets were being cut. Consultant support overall was being reduced and used only on existing research projects. Thus, the PBR consultant's time was initially not available to the committee and neither were formal rewards. Advancement on the social work career path would not require research participation and there were no other external motivators for MHP practitioners. Furthermore, because this group appeared to be composed of those MHP practitioners who were the most interested or motivated, it developed a model in which members would try to interest and motivate the "outside" group by serving as non-expert role models and mentors.

The Explicit and Implicit Assumptions at Work During the Pre-Rational Phase

The explicit assumptions made by research committee members in the first year of the committee's existence did not change greatly during the development of the risk project, as I will show, and were not questioned until late 1998 during in the time between program contact and implementation. They were as follows:

- Research could help improve practice and services if direct practitioners shaped and managed it.

- PBR would be the most appropriate approach as it would have the greatest chance of acceptance by able to staff - being the least intrusive into, and most compatible with, practice.
- A PBR approach would be the easiest to implement because it would not require that practitioners have research skills. It would build upon staff's practice knowledge, and so should require less technical help than other approaches.
- Research development would occur most effectively if practitioner participation was as voluntary as possible. Organizational directives should not be used.
- The committee's work must focus on developing staff interest, motivation and "buy-in."
- Participation in the research committee should be voluntary. .
- Rewards to direct practitioners for research participation would be largely intangible as it did not seem to be a necessary component for advancement on the social work career path.
- The committee would need to be persuasive in explaining to staff that research could contribute to direct practice.
- Despite the canonical position of the Social Work Department that research was a valued and expected activity for direct practitioners, cost cutting and other constraints meant that the committee would need to proceed alone initially. It would have to show success if it were to eventually obtain resources.

Implicit assumptions that the committee operated under, included the following:

- An incrementalist and opportunistic approach was more favorable than a planned programmatic research agenda.
- The impetus for development of potential research projects should be derived from practice and should not be seen to be generated by managers.
- Research development would require activism and advocacy from direct service workers on the committee but not from managers.

How did these assumptions fit with each other and with those of other systems within the organization? Within the macro system of the Social Work Department a canonical theory - that research is essential to practice - was being eroded by the need to focus on survival and the adjustment to a new practice environment. The rewards for research activity encoded formally in the career ladder, and informally in the organizational culture, were becoming less and less evident. These factors made the research committee's task much more difficult as it had few resources and was isolated.

How did the committee members own assumptions interact? During the pre-rational phase the committee evolved a working model. Officially this was described as a group of non-expert mentors who would work with other staff, outside the committee, to develop PBR projects. As the committee evolved there is evidence that this "canonical" model was gradually being replaced as committee members came to carry the burden of the committee's projects. As this happened the committee functioned less like a committee - with the status, formality and formal relationship to other program structures inherently suggested by the term - and more like a research support group, though these two characteristics coexisted.

Sidell et al. (1996) describe a similar research committee calling its methodology "a group approach" to research development, suggesting a similar interplay of formal and informal functions. However, the model the MHP research committee evolved reflects the circumstances that its members faced. Resources were scarce and the committee had little expertise of its own. Once a consultant was available, an hour monthly, the committee had to consider how to use this resource to develop multiple projects and to maintain the motivation of its own membership. The group model allowed the potential committee members to "mentor" multiple projects at one time.

How did the committee's assumptions about approaching research relate to those of other MHP practitioners? There is much evidence to suggest that the overall aspiration that formed the committee's *raison d'etre* - that practice could be enhanced by PBR - was generally shared by practitioners overall. In its formation the committee had assessed staff views and ideas for projects, and the responses strongly suggest that staff believed that this approach might help address long-standing practice problems.

The committee also believed that staff were wary of research and were hampered by their own lack of knowledge. There is a great deal of support for this idea in the literature on social work practice (Blythe & Briar, 1985; Epstein & Tripodi, 1978; Kirk et al., 1976; O'Hare, 1991; Penka & Kirk, 1991; Rosen & Mutschler, 1982; Turnbull et al., 1988; Wakefield & Kirk, 1996; Young, 1986) though there is considerable disagreement about why this might be. The research committee's own assessment of staff attitudes informed its view that it must help create interest and motivate staff.

The implicit assumption that the committee should work on a small scale in an incremental and opportunistic manner, one that became its modus operandi, was also well tailored to the circumstances. It fit with the macro-system dynamics within which social work was operating, i.e., too few resources and a preference for maintaining low visibility for non-service activities.

The choice to pursue small scale projects - consistently made between 1994 and June 1996 - also reflected ambivalence within the committee about a lack of research expertise in its membership and concern about nonmembers' attitudes toward research. The committee consistently acted on the premise that it must try to build a consensus of support of research. It chose to be cautious about the scale of its efforts and acted to avoid being perceived - by practitioner nonmembers - as imposing a research agenda upon the MHP. Committee members fell back on a clinical paradigm with which they had most experience - build motivation where opportunities best present themselves, approach change in small scale, incremental and gradual steps.

On reflection, my own approach to research development - the same as that taken by the research committee as a whole - differed greatly from my approach to other program development efforts. At that time, I was pursuing an active and sustained, more aggressive "change agenda" throughout the MHP. The development of a team-based approach and the mandate that all service staff develop both group work and community-based services, were examples of the more directive, broad and non incremental approaches to program development that was taking place elsewhere in the MHP. These were intensely focused efforts, and required a persistent and focused management effort. I approached the research committee work very differently. For me, it was a partnership with practitioners, a “breathing space” for exploration, reflection and learning. This contrast brings into question my own attitude toward research - as an unfamiliar arena that was distinct from my management practice.

The committee’s approach, and my own, also reflected the informal nature of organizational relationships within the MHP at the initiation of the research committee in the mid 1990's. As I will show in subsequent chapters, the MHP expanded and management became increasingly formal between 1995 and 1998. I created a management group that included team leaders and other key players that increasingly came to serve as the locus for service coordination, reorganization and development. However, the research committee did not become integrated into these efforts or coordinated with the programmatic agenda and with other program activities. It remained a highly informal vehicle.

Chapter VII. The Program Initiation Phase: The Risk Project Design and Development

1. An Overview of the Chapter

Between June 1996 and July 1997 the research committee's proposal for the development of a broad "MHP database" would evolve into the "risk project" - an effort to enhance intake processes through questionnaires. Eventually these questionnaires would be designed to assess clients' risk factors and attitudes toward help, family history, parents perspectives on their child's risks, and other related factors. The most appropriate metaphor for this evolution is that of a distillation process. Several related practice issues and programmatic concerns that had long been "in the air," but not formally considered a priority for action, were distilled, filtered and refined into a project. Time lines for the initiation phase are shown in Figure 3 (see page 133).

The planning and design process that led to the risk project's development was not highly rational, but was intuitive, explorative and inductive, its purpose evolving in a slow, indirect and sinuous process. During the initiation phase, the initial work took place mostly in the research committee and was continued by a loosely defined ad-hoc workgroup of practitioners. The project eventually returned to the research committee in the spring of 1997.

In this chapter I will describe this development from June 1996 until January 1997, when a first instrument was prepared for circulated to staff. Section two identifies the immediate precursors to the risk project in committee processes that occurred during the Summer of 1996. The focus of section three is the risk project "planning process" - or more accurately what was anticipated when the research committee began its work. Section four describes the forums in which the project was initiated, specifically the research committee and an ad-hoc work group.

Section five deals extensively with the way that the project took shape. It evolved from the initial, broad concept of an "MHP database" that would be used for PBR and program development purposes. It became a project in which clinical instruments were developed with the aim of enhancing assessment practices. The committee initially considered using existing, standardized instruments. This led to clarification that the committee really aspired to enhance the engagement process through the development of indigenous, holistic and comprehensive risk assessment tools - designed to invigorate the exchange between client and practitioner - rather than diagnostic or research tools.

Section six describes the role that discussions of comparisons between research and practice principles played in the risk project development and in shaping the finished AdQuest. These discussions led committee members to examine the lack of uniformity in common clinical practices within the MHP, such as the ways in which confidentiality and client consent to treatment were handled with clients. They concluded that PBR methods could enhance practice. I show how the AdQuest developed from a broad "risk inventory" into an indigenous instrument that was tailored to bring attention to issues to be discussed in the assessment interview.

In section seven I discuss the delays that occurred in risk project development during the second half of 1997 and their effect on the project. These delays may have portended issues about the committee's effectiveness that did not emerge openly until the implementation phase. However, at the time they were thought to be a result of the episodic nature of committee work caused by the limits of practitioner availability for project work that resulted from the highly "seasonal" nature of client utilization.

Finally, section eight concludes the chapter with my analysis of how the tasks of the initiation phase were framed by those who designed the AdQuest, and the explicit and implicit assumptions that were made throughout this process. The committee's original metaphor for the *risk project* - that of an "MHP database" was not a practice-friendly one. The evolution of this idea into one in which questionnaires would be developed to *enhance engagement* augured well for the project and is evidence that PBR was proving to be an effective means to bridge practitioners doubts about research.

Figure 3: Timelines for the Initiation Phase

June 1996 to January 1998

☐ 1996

THE INITIATION PHASE BEGINS
JULY 1996

◇ July - October 1996, MHP "Database" discussed
- ○ Committee formes exploratory "break-out groups"
- ○ Focus developed on risk assessment and first stages of client enrolment in services

◇ November 1996, Risk Project initiated:
- ○ Goals are defined as an attempt to improve assessment methodology

☐ 1997

- ○ Committee focuses on the initial contract & risk assessment
- ○ Begins to consider engagement and client self assessment
- ○ A Risk Inventory is developed
- ○ RAIs are considered and rejected as too diagnostic & not focused on client engagement
- ○ An existing risk assessment instrument - the YRBS - is considered and rejected in favor of the development of contextual, indigenous instruments
- ○ The AdQuest, an indigenous, contextual "risk assessment & engagement tool" is drafted

◇ A second project group is formed- to redesign service records to complement & work in conjunction with the AdQuest

◇ The risk project is delayed as the service record workgroup ends after psychiatrist leaves MHP

☐ 1998

◇ The risk project is renewed: a decision is made to proceed without a revision of the service record

2. Immediate Precursors to the Risk project: Developments within the Research Committee: June 1996

The first discussions of using a PBR approach to improve engagement was discussed in the research committee in June 1995 but gained traction only the following year. Then, in the summer of 1996, the committee held more vigorous and sustained discussions about this issue than ever before. Eventually members decided to initiate a project which was named the "mental health database," inferring that over time it would generate information about overall program practice, client activity and outcomes and serve as an available information goldmine for PBR projects. Even as the project focus was narrowed and clarified, the name database remained in use until late 1997 when it began to be replaced by the term "risk study."

Committee minutes show several circumstances that influenced its willingness to proceed on a large-scale, program-wide project that involved the whole committee, at this time. First, a number of small-scale committee projects appeared to be established and as it planned for the year ahead, the committee was looking for new initiatives and finding easily-identifiable opportunities. Those practitioners who had been most interested in research activities were involved in projects and most were involved in the committee. Second, two practitioners from the HIV program - one, a research committee member - had seen an exemplar of PBR used to enhance clinical assessment processes at a recent conference. They were enthusiastic and eager to address the MHP assessment practices to make them more rigorous and consistent. Third, the committee had been discussing long-standing practice issues related to how intake and engagement processes might be enhanced to improve retention in treatment. The themes seen in the committee minutes can be captured in the following questions that were being discussed. What did new clients expect from services? How did the referral process and source influence client motivation? What did clients see as the consequences of engaging in, or dropping from services? What was the client's perception of the treatment contract and what was the direct practitioner's? What relationships could be seen between client risk factors and client perceptions of the need for services? What was the relationship between client risk and client utilization patterns?

Though these themes were derived from long-standing concerns, their emergence at this time appears influenced by learning derived from the committee's other projects. Preliminary findings from the termination study suggested that adolescents tended to terminate without any discussion with their practitioner but, despite this, unplanned terminations did not appear to be related to satisfaction or dissatisfaction with treatment. Presentations of these findings raised questions about the processes by which clients were initiated into services and the treatment contracting process.

Attention was being drawn to the usefulness of having available data in the form of standardized clinical information as part of the service record by the psychosocial sequellae to violence study and the termination study. The former provided a positive exemplar as it utilized available data obtained from health history surveys given annually the AC's school health centers. Though the information these surveys contained was limited in scope, it was easily obtainable and standardized. The termination study, in which data was being drawn from narrative style progress notes in the service record, drew attention to the unevenness of narrative notes, their variability in content, style and focus, and the limitations this posed for obtaining readily available and useful information. These issues were highlighted by the difficulties the social work supervisor and I were having in obtaining data for annual reports to various funders, and the intensive effort this required due to a lack of available information. Using PBR to make the assessment process and the client record more holistic, uniform and rigorous was an increasingly attractive idea.

A fourth factor in the committee's emerging willingness to embark on a large project can be deduced from other committee processes. The committee was more established than it had been in 1995 and feedback, from its existing projects suggested further avenues for exploration and highlighted programmatic needs. Committee discussion no longer seemed dichotomized between "clinical" and "program" issues as is clear from the themes of its summer and fall 1996 meetings. This is evidence that the committee was serving to bridge the dichotomy between clinical practice and management, as was the fact that for the first time the committee was no longer emphasizing small-scale studies.

3. Planning for the Risk Project: What was Anticipated?

Planning occurred as an incremental evolution rather than as part of a discrete and rational phase and as such at this time the committee was discussing a broad "effort" rather than a discrete project. The "mental health database" was still very loosely defined, though the group anticipated that it would have several characteristics. First and foremost, it would be broad in scope. Committee members had identified many interests related to engaging and retaining clients, the overarching theme of interest. These included studying the nature of the referral process and the client's understanding of it, expectations of treatment, client motivation, the client's prior experiences of "help," risk factors, family functioning, and family history.

It was also intended that the effort might have multiple-components and multiple sources of information. Many suggestions were on the table, including developing questionnaires to be used at different points in each client's clinic career, telephone interviews with referrers and other key informants, and a more research-friendly service record. The group thought that it would approach this effort incrementally, with the staged implementation of individual components in the form of small projects. This reflected concern that PBR projects should be manageable and produce tangible rewards, to maintain staff interest and motivation. One lesson learned from the experience of the brief treatment study, was that projects that would take time to complete should be phased so that demonstrable rewards would be experienced at each phase to maintain the interest of participants. This was thought to be essential to maintaining a strong connection between clinical and research efforts as is a tenet of PBR.

The committee strongly felt that the innovation effort should enhance practice, at the very least by generating information that practitioners would find directly helpful. One idea was that the format of the service record could be redesigned to integrate information derived from the project and simplified so as to reduce the work of writing service notes. If questionnaires were used during the intake process assessment interview formats could be restructured to follow the sequence of issues explored in questionnaire form. It was acknowledged that, because at a minimum the records of service would need redesigning, others outside the committee would have to be involved. Beyond this acknowledgment it was not possible to identify who else should be included at this time, and the committee still had to consider how its own membership would participate. Only in January 1997, as the risk project began to emerge as a first component of the overall effort in until January 1997 did the group further consider whom outside the committee should be included, at which point the staff psychiatrist was involved.

Though it was assumed that the whole committee would be involved in this innovation effort, members did not discuss the impact the overall effort might have on the committee. Though this may seem to contradict the committee's long-standing hesitancy to immerse itself in one large single research project, the effort was not yet viewed as a single "project." The assumption was that a unified whole would be comprised of distinct components each of which might be developed semi-autonomously, involving its own small group of practitioners, and having its own objectives, rationale, and time lines. The metaphor that arose in the committee was that the overall innovation would be a "mosaic" of small, committee-led PBR projects.

By the end of October 1996 the committee had developed written goals for the project. These were (1) to provide baseline information on client risks and client expectations of services; (2) to improve clinical assessment practices by developing uniform standards and methods, including identification of risks; (3) to enhance program development; (4) to create a database that could be used for other PBR studies, and; (5)

to help preserve existing grant funds and to assist in the development of new service grants through the more systematic collection and reporting of information.

A preliminary sketch, developed in the fall of 1997, suggested that information might be collected through a series of components. These might include the development of questionnaires specifically developed for the practice context as well as the use of existing instruments, though no particular ones had yet been identified. One suggestion was to enhance intake assessment through more rigorous collection of family information. Implementation of different project components could be staged and individual practitioners might develop projects that related to different areas of clinical interest.

4. Participants in the Initiation Phase

Because it was thought that the existing project would be a committee effort, it was not necessary at this time to develop a separate project team. The committee initially worked together as the risk project developed and served as a reference group throughout this project. Paradoxically, though many committee members had considerable participation in the risk project's development, it never truly became a committee project. Many committee members were completing their own projects, initiated in 1995, and as I describe in the Chapter VIII, periods of tension later arose about the risk project diverting attention and resources away from their other efforts.

During the initiation phase, risk project work moved between the research committee and a loosely defined workgroup. From October to November 1996 the full research committee worked on it. During December 1996 the committee formed four small groups of its own members to explore potential project components. In January 1997, an ad-hoc work group, which included some research committee members and some nonmembers worked to develop an adolescent questionnaire. Other direct service staff were involved informally from time to time. From March onwards the research committee devoted about a half hour monthly, that is about 20% of its time, to the risk project.

5. Evolving Design decisions

The evolution of the risk project involved exchanges and decisions, primarily within the research committee, on a number of interrelated issues. These were co-occurring and overlapping but, for purposes of clearer iteration, I will categorize them.

Finding a Starting Point

The committee's original sketch for a "mental health database" included a broad range of possibilities included staged projects relating to specific points of each client's clinic career or to specific areas of interest. Defining a practical starting point was crucial as the committee felt each component should be clearly defined and self-sustained, to maintain staff interest with tangible, short-term rewards. Overall concern with the entry of clients into services led to a decision to focus on assessment and engagement.

Narrowing Down: The Formulation of Risk Project Goals

On what aspects of engagement should the committee focus its first effort? In mid-November 1996, overall goals were formulated. This would help define an initial project. The project should (1) develop more rigorous and pertinent clinical information regarding client risk behaviors, (2) lead to more uniform assessment processes, and (3) help staff understand better who clients are, why they are coming and what they want from services. While still broad, these goals were more focused than those articulated six weeks earlier.

By the end of December 1996 the immediate objectives were defined as: enhancing client assessment by making it more uniform; producing information about each individual client that was accessible and useful to clinicians, and; providing aggregate information for program use. Committee members wanted to ensure that the project did not increase the work of direct service staff and if checklists were developed there might be potential efficiencies in the documentation of services that might reduce practitioners' voluminous work in recording their assessments.

The ongoing design process meant a constant refocusing and distillation. In November 1997, a number of loosely defined areas of interest, which might serve as project components, were on the table. These were: (1) client's history of help;

(2) referral processes (including each client's understanding of the referral reasons and the perceived consequences of seeking or refusing services; (3) client expectations of the service and attitudes toward help; (4) client risk behaviors; (5) client psychosocial functioning (school functioning; peer and social interactions; (6) health and psychiatric history), and; (7) family circumstances, family functioning and family risk factors.

In December 1996, the committee broke into four small task-based groups to explore project components. Each group consisted of two or three research committee members assigned on the basis of interest. They were: (1) expectations and motivation; (2) risk behaviors and peer interactions; (3) school functioning; and (4) health. The committee decided that a family assessment tool could be developed as a separate project later on, so this area was set aside. The interest in referral sources and referral processes was dropped as it was also seen as a separate project that related to process largely outside of the agency's sphere of influence.

Even as the project became focused on client risks, problems and expectations, committee members continued to call it "the MHP database." For the committee to maintain this metaphor, with its implication that this undertaking was a large and sweeping research project rather than an information-based clinical innovation, bore several implications. First, the tendency to use research language allowed the committee of practitioners, who felt research to be quite different from practice, to hold the project at a distance. Second, the practitioners approached it as impersonal and as yet disconnected from their practice - it was as if they were advancing upon unfamiliar territory. Lastly, this phenomenon embodied the tense dichotomy between research and practice and I later realized that this approach spoke to the point that practitioners often underestimate their skills and what they have learned, a circumstance that I will discuss in Chapter X.

When the four small work groups reconvened at the end of December 1996 a number of components had been drafted, they varied considerably in approach and specificity. The group interested in clients' expectations of treatment had developed a guide for a qualitative interview with the client, with a series of questions that might be asked at the time of referral. The health group had drafted four questions to be asked of clients about their health status and mental status. The school group had generated a list of possible questions focused on school performance.

The most developed section was that on risk behaviors, that I and a practitioner from the HIV team had worked on. This was arranged as a crude inventory for inclusion in a self-administered questionnaire in the form of a checklist of risk behaviors. It can be found in Appendix B. Risk factors and risk behaviors were drawn from the clinical experience of practitioners, supplemented by a literature review which I conducted. As I noted earlier, the HIV team was extremely experienced in clinically assessing high risk youth and we studied their methods for assessing sexual behaviors, and associated risks, such as sexual decision-making, assertiveness and substance abuse. Over time, this component became the basis of the overall risk project and the two of us who developed it became identified as the project leaders.

This preliminary work formed the foundation for the next step. This was the formation of an ad-hoc project group of seven staff, five of whom where committee members, who could meet independently of committee meeting times to develop the project. One member of the group was not on staff but was a practitioner with experience using indigenous instruments to identify high risk youth, visiting as part of an international fellowship program and assigned to the AC for three months. This group met intensively, many hours weekly, over the next two months- January and February 1997. Its goal was to shape and form the work done to date into an initial questionnaire or questionnaires. In May of 1997 the group had what it considered to be a draft of an adolescent risk assessment questionnaire that could be used within the MHP practice.

Predicting risk factors versus Learning about client behaviors and attitudes

The ad-hoc project group was primarily interested in developing tools to help assess each client's functioning, risk behaviors and other risk factors, problems, and expectations of what they might address through agency services. First it decided which issues were best assessed through the current, interpersonally-based assessment interview methods. Although there was acknowledgment that, at some point, a taxonomy of risks and problems might be developed, the group felt that exploration of the presenting problem should be assessed by the practitioner as this process is one of exploration, framing and reframing, between client and practitioner. This should not be addressed through instruments. Rather, the interest was in component risk behaviors and risk factors and attitudes toward them. Concerned with the differences between clients' views of their needs and the apparently broader formulation of problems that practitioners tended to develop, the group focused on a process of discovery related to issues that might not get covered in a problem-focused interview. Clients overall risk behaviors, their perceptions of their own behaviors and needs, and attitudes of those around them became the focus, as these were currently not fully inventoried and explored in any routine way.

Epstein (1995) has underscored the limitations of standardized instruments for practice application. He notes that, among other problems, standardized instruments are not closely linked to practice theory and "for all their 'psychometric robustness' are rarely shown to be predictive of setting-relevant behavioral outcomes" (p. 7). He suggests that indigenous, context-specific instruments are generally most helpful to clinical practice. Perhaps in ignorance of this, the workgroup next began an effort, which it later abandoned, to try to identify available instruments that might be used as part of the project. The decision to explore the use of RAIs may reflect the fact that the group was not yet sure of its own purposes and values, or confident in acting on the basis of practice-knowledge.

Members discussed the possibility of using rapid assessment instruments (RAIs) for assessment purposes and a number were identified. These included the Child Behavior Checklist (CBCL) (Achenbach, 1991), the Beck Depression Inventory (Beck, 1967), Offer's (1967, 1972) Adolescent Self Esteem Questionnaire, and the Coopersmith Self Esteem Inventory (Coopersmith, 1959; 1967). Discussion of what these instruments might achieve helped the group reexamine and clarify the purpose of the risk project. Should it identify high risk clients by using RAIs to diagnose or predict problems, such depression or low self esteem, or generate client-specific information about risk behaviors and attitudes to create an exchange between practitioners and clients?

RAIs were put aside as the group decided that it was less interested in diagnostic tools than in tools that could *aid engagement by creating discussion between* *clinician and client about each one's perceptions of the client's behaviors.* The perception was that RAIs would not serve to do this across a broad array of adolescent issues relevant to the AC's population of inner-city adolescents of color. Clinicians in the workgroup regarded RAIs as "impersonal" and unnecessary as they viewed current interpersonal assessment practices as effective in enough diagnosing problems in mental status. None of the design group was familiar with RAIs and were used within the practice at that time.[1] The fact that the workgroup decided that it did not need diagnostic tools and that interpersonal techniques were effective and efficient enough supports Epstein's (1995) suggestion that standardized instruments rarely capture the range and subtlety of the information that clinicians consider most important. It also suggests that the workgroup was developing a growing confidence in its own values and viewpoints.

The abandonment of RAIs was consistent with the group's goals of having detailed and specific information about each client to use as an engagement tool and to develop a program database. It was also suggestive of the practice culture in which clinical judgement and clinician autonomy were highly valued, and of the view point of many "interpersonal " practitioners. Max Siporin (1988), among others, (Goldstein, E., 1986; Goldstein, H., 1986; 1993; Kolevzon & Maykranz, 1982), has described the common view among practitioners that practice is an art and not a science and Schon

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[1] The hiring of two psychologists, who routinely used both RAIs and other diagnostic tools, led to this issue being revisited when the FamQuest was finally developed in the fall of 1998. One RAI, the Child Behavior Checklist (CBCL) (American Psychiatric association, 1994) was also introduced into the practice that same year by a newly hired psychiatrist. While the CBCL became widely used, one non-social worker viewed this as a result of its being useful to gain quicker psychiatric evaluations. This is described further in Chapter VIII.

(1983) has suggested that in the world of professional practice relevance must often take precedence over rigor.

My own explorative study of practitioners' experience with the brief treatment model, that I described in Chapter VI, suggested that MHP practitioners placed great value on forming a "relationship" with the client. Later, during the implementation phase I came to understand the "value" of this relationship in helping practitioners tolerate the uncertainty of working with "risky" adolescents with the confidentiality usually allowed adults. During the first interview - at which a parent was present only about 50% of the time - practitioners must be able to begin this engagement. This meant creating an atmosphere that would encourage the client to return while making sure that they had sufficiently explored the presenting problem and were comfortable for the time-being with their own assessment.

The perception that RAIs might interfere with the engagement process suggested that the organizational culture within the MHP practice placed high value on the art of assessment and engagement. Though there may be several interpretations as to the meaning of this, two in particular are relevant. The rejection of RAIs may suggest that practitioners' attitudes toward instruments overall, including indigenous clinical assessment tools, should have been considered. Later, as I will discuss in Chapter IX, such attitudes may have affected the implementation of the risk project. However, an alternative theory is that among the practitioners who were participating in developing the risk project, the rejection of RAIs showed their burgeoning confidence in their own judgement, in decision-making grounded in practice-knowledge, and in their growing grasp of PBR.

The Use of Existing, Standardized Risk Assessment Instruments Versus the Development of Indigenous, Contextual Tools

A search for existing, comprehensive risk assessment instruments revealed only one that addressed the wide array of risk factors affecting adolescents. This was the Youth Risk Behavior Survey (YRBS) (Commonwealth of Massachusetts Department of Education, 1993) developed for use in schools and since widely used. (Centers for Disease Control, 1999; Search Institute, 1999) With growing confidence in its own judgement and with a clearer sense of direction, the group rejected this extensive survey questionnaire as unsuitable for the MHP setting.

Epstein's (1995) observation that standardized instruments are often less than helpful to practitioners was born out. Among the problems he notes are that standardized instruments are often "too long and cumbersome" (p. 6) and "have been standardized on different populations" (p. 7). This was also the conclusion reached by MHP practitioners about the YRBS. It required an additional hour-and-a-half interview to complete which was considered impractical and viewed as creating a significant barrier to engagement as it would delay the exploration of the client's presenting problems.

The group identified several other concerns with the YRBS. First, the 89 item, multiple-choice questionnaire required an hour - or more - for completion and was considered impractical. It would create a barrier to services and considerably delay exploration of the presenting problem. Second, it focused on risk behaviors and did not explore other factors seen as relevant to the practice context. The workgroup members wanted not only to assess each client's risk behaviors but also to develop some indicators of each client's attitude regarding those risks, and whether he or she considered them as issues for discussion. Third, the YRBS derived its risk factors based on national patterns. It was not viewed as addressing the specific patterns identified as particularly relevant to the MHP. It was thought that certain items on the YRBS - such as the nutritional assessment and the assessment of risk related to bicycle riding - would divert the focus away from more pressing issues such as racial issues, violence, gang activity, poverty and so on. Even as it decided not to use the YRBS, the group was aware that it was compromising its ability to conduct comparative studies by not using a nationally accepted standardized instrument. It made the conscious decision that practice relevance should take precedence over research rigor.

Group members became clearer that they wanted an instrument that could be used with minimal intrusion into the engagement and assessment process. The YRBS did serve as an exemplar for areas of risk assessment which might help guide development of a contextual tool both in terms of what it included and what the group felt was missing from it.

During January 1997, the group began design of an adolescent questionnaire which was being called the "adolescent self assessment risk questionnaire." It planned to simplify the agency's assessment reporting forms, that many practitioners considered burdensome, so that these forms followed the same sequence of subject areas as the questionnaire, which I will refer to as the AdQuest, the name that was eventually given to it. Wherever possible, the plan was that the assessment record would be changed from a narrative format to a checklist format.

The Introduction of Instruments into Clinical Processes: At What Point to Begin

Having committed to develop a contextual, PBR instrument into the assessment process, the group decided that an ideal first step could be the development of a questionnaire suitable for completion before the first interview. It also acknowledged that this was a difficult starting point, as there might be concern among practitioners about instruments interfering with engagement of clients. However, the group concluded that an instrument might also enhance engagement by creating a vehicle for discussion, and by indirectly informing clients about AC's service philosophy, services, expertise and ability to talk with adolescents about their lives. A questionnaire could be constructed in a way that educated clients about the AC's services and service approach. As one member put it "we can develop an *engagement tool*" that "lets clients know that this place is prepared to help them." This metaphorical shift from a "database" to an "engagement tool" is noteworthy because it suggests that the committee practitioners were becoming more comfortable with PBR - they were seeing it as syntonic with practice rather than as unfamiliar territory.

Yet ambivalence about research and instruments remained evident. A chief reason the group chose to introduce and instrument prior to intake was because it reached a consensus that "from a research perspective this would result in cleaner data." It was thought that adolescents would be more forthcoming about the details of their behaviors before they had entered into a relationship with a clinician and together developed a personal narrative about why they were presenting for services. Many practitioners in the group stated that it was not uncommon for their clients to try to reassure their therapist in the face of the therapist's demonstrated concern. It was thought likely that in the interpersonal encounter - client with practitioner - clients would minimize their risks. Giving a questionnaire, after they had begun to establish their narrative, might make it difficult for them to answer honestly as it might require some embarrassing reversals and revisions. Practitioners were clear that they wanted to derive information that was as clinically valid, reliable, and accurate as possible.

Who to include: Key constituents

Because the risk project as proposed should impact every clinician and client in the MHP, committee members thought they must secure its acceptance by practitioners. The way to do this, it was assumed, was to address their concerns which would be mostly related to research. The impact of the project on clinical practices and the need to work with practitioners on integrating a questionnaire into practice was not addressed at this time. Another idea, that the committee thought would provide an incentive to other practitioners, was to revise the clinical record to make documentation of services less burdensome.

Awareness of the need to plan for the impact on staff was overshadowed by the greater concern about the potential impact of the project on clients. This concern stayed in sharp focus even after the project was clearly defined by members as "clinical" in nature. In stark contrast to the lack of planning to address the impact on staff, the group addressed their concerns about clients through careful planning that led to the use of focus group methodology and careful piloting with long-term clients, as I will describe later in Chapter XIII. At least five, hour-long meetings were being devoted to working on this issue. In comparison, only one committee meeting was devoted to the issue of how to involve practitioners, and this was at the end of the design phase.

The work of securing the practitioners' support, and addressing any concerns they might have, was not totally overlooked. The committee did not think it necessary to address this task yet. In addition, the practitioners on the committee were pleased with the instrument and thought that it would work well in the practice. Staff would "buy into" the project once the assessment forms were simplified, a task that was identified as necessary to motivate other practitioners. Because of this, the program psychiatrist, who would have to approve any such changes, joined the project workgroup in January 1997, and in May 1997 formed a small group to start the redesign of intake forms.

The risk project work group began the development of the AdQuest as an instrument that could be used in the assessment process. The starting point for this process was the risk inventory developed in November 1996 which can be found in Appendix A. I will now describe the influence that discussions between research and practice considerations had in shaping this into the finished AdQuest which can be found in Appendix C.

The views of those who participated in the development of the AdQuest of regarding the nature of the project shifted as it moved forward. Although it had a PBR foundation there was a subtle shift from a research-focused project to a stronger practice focus. However, even after the committee had formally decided to develop a clinical tool, underlying concerns that the risk project was research - a perception perhaps reinforced by the fact that it would provide aggregate clinical information for the MHP - continued to affect the decision-making process.

6. Research - Practice Exchanges During the Initiation Phase

In this section I will show how tensions between research and practice methods ran throughout the development of the AdQuest and how the project and workgroup were enhanced when these tensions were made explicit. In contrast, when tensions about the impact of research on practice remained implicit, unrecognized undercurrents, poor decision-making resulted.

There was awareness of the interplay between research and practice agendas as the differences between them were discussed frequently throughout the project's development. There was great concern that the project should become well integrated into clinical processes. Many participants discussed their perceptions that, too often, research projects did not seem to provide useful information to clinicians and led to a negative experience of research implementation. This discussion helped the group decide to shape the risk project into more of a "clinical" than a "research" endeavor.

Sometimes a view of the AdQuest as primarily a research instrument influenced the decision making process. For example, when deciding where in the assessment process it should plan to introduce the AdQuest there was a consensus in the committee that gathering data about risks prior to the first interview would lead to "cleaner data." This was viewed as most desirable from a research perspective.

Similarly, introduction of the AdQuest on the first visit would result in "collection of data" on a larger number of adolescents as it would include the clients who might drop from treatment during the intake process. One member suggested a research study could be done regarding the differences between those who dropped during the assessment process and those stayed in treatment.

Discussions of the differences between a "research protocol" and the AdQuest as an "extension" of the practitioner occurred during a number of meetings and covered a range of issues related to engagement, consent and confidentiality. These discussions were prompted by the concern, shared by most practitioners in the group, that the client's first encounter - in which he or she was asked to describe his or her behaviors, risks or concerns - should be with a practitioner.

The first concern was related to engagement. Would using an instrument seem impersonal and intrusive and would this prevent or disrupt the engagement process? This discussion refocused the group from concern about intrusiveness to the desire to develop an instrument that would prepare the client for the first interview and educate them about services and service approach. This led the group to identify the importance of sequencing and grouping questions so that they flowed easily, from the "social" to the more personal and intrusive, just as a clinical interview might flow. This discussion also helped widen the focus from a simple "risk inventory," as shown in Appendix B, to an instrument that was more generally explorative, but deliberately imparted information to adolescents, and complemented the flow of the intake interview. One result was the decision to divide the questionnaire into sections that moved from a general introduction through several relevant topic areas. These are illustrated as Figure 4 (see page 155).

Figure 4: The Evolution of The AdQuest: Questionnaire Components and Their Sequencing

Component 1: Statement of how the AdQuest will help the practitioner to help the client.

Component 2: Personal information
◊ demographic information & experience of racism

Component 3: School & Work

◊ how the client rates his or her school
◊ school performance
◊ school attendance

Component 4: Safety

◊ feelings of safety
◊ exposure to violence - victimization, sexual violence, relationship violence
◊ risky behaviors of self or friends
◊ feelings of suicidility

Component 5: Health

◊ rating of health overall
◊ weight worries, eating habits, eating disorders
◊ psychosomatic symptoms

Component 6: Health - Sex & Sexuality

◊ sexual orientation & gender identity
◊ knowledge about sex & sexuality
◊ ever had sex
◊ ever been pregnant / gotten someone else pregnant
◊ sex and drugs
◊ contraception & safe sex
◊ any questions about sex, body or birth control

Component 7: Health Cigarettes, Alcohol & Drugs

◊ been offered drugs
◊ tobacco, alcohol and drug use - ever
◊ tobacco, alcohol and drug use - in last month
◊ worries - about own use, and family and friends worries about client
◊ friends and family drug & alcohol use

Component 8: Friends & Family

◊ relationships with friends
◊ family worries about client & friends
◊ losses
◊ family & home life
◊ spirituality & religion
◊ other concerns not covered, comments & questions

Creating topic areas, such as "health" and "safety" might also allow risks to be explored in a non problem-focused, non-pathological way. For example sexual behavior would be included in a health section, "normalizing" sexuality. Questions about sexual assault would be included in a "safety" section, sending a message that adolescents had the right to safety and well-being.

The second concern related to consent. A question emerged: would clients consent to *research participation* be necessary, and if so should it be a verbal or signed? Practitioners were concerned not with the legal issues but with a feeling that there should be proper disclosure to clients and full discussion of the project. A consensus on consent evolved only as the group debated whether the project was a research project or a practice innovation. This led to consideration of the existing organizational practice. The informality of the culture and the deliberate and considered avoidance of having parental consent for treatment had meant that the issue of client consent to services and treatment was largely ignored. At that time, written consent to treatment was only used when psychotropic medications were to be prescribed.

Committee members agreed that this was more a practice issue, for the agency, than a research issue. Despite the consensus that the issue was not research consent but consent to treatment, the view that clients should be able to refuse to complete the AdQuest reemerged during the implementation phase even though no one felt that clients should be asked of they would like to refuse services. This suggests that many participants continued to feel uncertain about the nature of the AdQuest as if it was in some way, "external" to practice.

Similarly, confidentiality was a great concern. Could the AdQuest be given to a client before confidentiality and its limits had been discussed? Agency practices gave wide leeway to practitioners for maintaining confidentiality. Adolescents could be seen without parental consent. Parents were only informed that a client was in treatment without a client's approval if the client was deemed to be at immediate risk for his or her own safety or that of others. Suicidality, homicidality or abuse were among the few factors which would lead to parental notification without a client's consent. If the AdQuest was completed before the client had been seen by a clinician how would the parameters of agency practice be explained?

Exploration of this issue led to discussion of current clinical practices and the identification of inconsistencies between different practitioners as it became clear that confidentiality was not handled with any uniformity. Written guidelines or protocols were not used even in the orientation of new staff. Again, a consensus was reached that the weakness was in overall agency practices. Members were excited that the project had brought attention to a number of issues that, if addressed, could improve current practices.

As a clinical protocol, the AdQuest would be included in the service record and therefore concerns about confidentiality helped shape its content. The group dropped any questions that might involve implications of criminality - gang membership, violent activity or weapons' possession - many of which were explored in the YRBS. It was considered unethical to ask questions that might result in a client's self incrimination before the limits of confidentiality in the treatment relationship, and of the service record had been discussed. It seemed apparent that such issues might currently be discussed yet not documented by practitioners.

These discussions honed the instruments and their implementation protocols. For example, the committee minutes note discussion of the question, "what is the research role of direct service staff in the clinical intake session?" This question related to the purposes of the information gathering and the need to remain focused on client engagement. This influenced decisions about what to include or exclude in the AdQuest. The minutes note a committee decision that, "if anything is compromised it must be on the research side not the practice side." Inclusion of items in the questionnaire was to be driven by direct practice needs not research interests and this helped the group to focus on developing an instrument that most adolescents would be able to complete in less than twenty minutes and that would be designed to be highly congruent with clinical practices during the assessment and engagement process.

The AdQuest became less and less an inventory of questions about risk and much more refined as a clinical tool. For example, a dozen questions that related to feelings of safety - in the neighborhood, school, home, and among friends, feelings of suicidality and so on - were eventually distilled into two questions which follow (the question numbers reference the AdQuest, see Appendix C):

24 Do you ever feel unsafe? Yes___ No ____

36. In general, when it comes to your own safety, how often do you feel unsafe?

1	2	3	4	5
Always	Often	Sometimes	Rarely	Never

A "yes" response to the question on safety could have many interpretations, all of which could be uncovered by the practitioner. An alternative response might mean the respondent was being abused at home, was living in an unsafe neighborhood, was paranoid, was suicidal, or was feeling "out of control" in some manner. The "research agenda," i.e., obtaining detailed and specific information, took second place to practice relevance. It was also thought that if the assessment forms completed by the practitioners were more "research friendly," in the form of checklists, that research data would still be easily obtainable by chart review. Direct practitioners in the committee termed the question on safety a "tickler question" that was designed to precipitate a practitioner's inquiry. They became excited about how this simple approach could be a powerful enhancement to the assessment process.

The group also considered using open-ended questions that elicited qualitative responses, but decided not to use this approach. The experience of the summer of 1995 during the marketing and client satisfaction survey, which I described in Chapter VI, suggested that many MHP clients tended not to respond to open-ended questions - they simply left them blank. Practitioners realized that clients would respond to open-ended questions in an interview format, but not on a written questionnaire. It was intended that the clinician would extract the qualitative information in an interview after the client answered the items on the questionnaire. The goal was for the instrument to be a component of assessment.

In moving away from a risk inventory approach the group opened up opportunities to draw upon its own practice wisdom in the design of the AdQuest. Practitioners began to discuss the experience - that they viewed as a common phenomenon - of seeing adolescent distress being minimized by parents. They believed when parents overlooked or minimized their child's concerns overall risk was magnified. They wanted to be able to compare adolescent's views with those of parents. This resulted in the development of questions asking each adolescent to assess how well they felt they were coping, and their levels of worry, regarding a number of issues, to supplement the exploration of specific behaviors. In addition, questions were developed regarding the client's perception of his or her parent/parents' levels of worry and those of friends, and about their willingness to discuss these issues in treatment. This set of questions was added at the end of each section of the questionnaire. Figure 5 (page 161) illustrates this series of questions as they appear on the AdQuest section on sexuality. Practitioners considered these types of questions as potentially valuable in providing the basis for a discussion of barriers to engagement.

Figure 5: Exploration of Adolescent Perceptions of Coping Skills and Worries - Samples from the AdQuest regarding sexuality

52 **Do you ever worry about anything to do with sex, your body or birth control?** **Yes__ No__**

53 **Do you have any questions or concerns about sex, your body, or birth control?** **Yes__No__ Don't Know__**

54 **Do your friends or family members ever worry about your sexual behavior?** **Yes__No__ Don't Know__**

55 **When it comes to sex, your body and birth control how would you say you are doing?**

1	**2**	**3**	**4**	**5**
Very Poor	**Poor**	**Average**	**Well**	**Very well**

56 **How much do you want to talk to your counselor here about anything to do with sex, your body or birth control?**

1	**2**	**3**	
Not At All	**Somewhat**	**Very Much**	**Don't Know __**

7. Project Delays

Plans for introduction of the AdQuest to the staff were set the Fall of 1997 and implementation for January 1998 but did not materialize as for the next six months, little work was done on the AdQuest or any other components of the risk project. A major problem was in the planned redesigning of the service record, a task that committee members considered to be most difficult. The psychiatrist was to lead this effort, as she was responsible for insuring that the service record complied with legal mandates. Her resignation in July 1997, and difficulties in recruiting a replacement resulted in temporary coverage until August 1998. This setback meant that the service record was never redesigned. As I will describe in Chapter X, this effort was eventually postponed indefinitely and was resumed only after initiation of the AdQuest in early 1999.

A second contributor was an overall delay in the work of the research committee. Research Committee co-leaders had recognized that the committee work was "seasonal," progressing in times of lowest service utilization, particularly the summer months and a brief period in winter. However difficulties within the committee that emerged later, as I describe in Chapter VIII, suggest that the risk project was taking its toll on a committee that was already burdened with other projects. Lack of a specific risk project group within the committee, or separate from it, was also a significant problem as there was no identified "champion" for the project.

8. An Analysis of The Initiation Phase

Explicit assumptions made by the research committee members about the committee's value as a vehicle for bridging direct practice, management and research, and about the value of PBR as a methodology, were the guiding principles that led to the risk project. However, the group began to question the committee's effectiveness and structure a year after it had embarked on a program-wide initiative that was to involve its whole membership and considerable amounts of its time.

In embarking on the risk project the committee assumed a new role in which a program-wide effort would result in greater visibility and a greater need for planning. This need for planning included the sequencing of potential component projects, consideration of the impact of the project on the committee, coordination of the project with program management, and the consideration of its impact on the organizational culture, and on staff and their practice. This latter need relates to what Thomas (1979) refers to as the human and technical subsystems of the organization. In addition, a plan for the change in the structure and content of the service record would necessitate a sustained effort, that was not achieved at this point. Overall, as I will show, considerable attention was given to the impact of the innovation on clients, little to its impact on staff. It is also clear that, as the committee began work on the project, it continued its informal and incremental approach and did not shift to a greater planning role.

The Committee's Assumptions About its Approach: Enhancing Practice and Program and Bridging the Practice-Research Dichotomy

As it considered the risk project, the committee believed that a PBR approach could be used to enhance practice, particularly the assessment and intake process, while simultaneously developing a platform of clinical information for program development. In this way, it would combine practice and program goals and research and practice methodologies.

The goals of the risk project articulated an attempt to enhance three areas of practice. The clinical purpose was the development of assessment instruments. The programmatic purpose was the collection of aggregate data related to clients' risks. The research purpose was to develop a system for information-gathering that would provide the basis for research projects. The research committee function was to serve as the vehicle for bridging each of these areas by empowering practitioners to develop PBR.

As the AdQuest was developed, an explicit assumption was made that PBR methods could enhance client engagement by creating a basis for discussion of each adolescent's world: his views of his risks and need for help, and the views of those around him. Not until the program contact phase would it be known if this was happening. However, already in the initiation phase the project had given strong indications that it could help organizational practices as there had been an identification and discussion of a number of practices that stood to be enhanced as the project got underway. These included lack of uniformity and rigorousness in assessment practices, limitations in the current service records, lack of clarity and protocols regarding consent for services, and the considerable variation among practitioners in the handling of confidentiality with clients.

The risk project used PBR methodology to enhance and develop the clinical services and to create the capacity for program development and the development of research projects. Consistent with Epstein's (1995) description of PBR, the project attempted to combine elements of both practice and research methods to bridge the practice-research dichotomy. True to PBR methodology, its instrumentation was developed to be tailored to practice and did not utilize standardized research measures. Practice considerations generally outweighed research considerations. However, in many of the communications about the project, concern about research remained prominent.

Unexpressed and Underlying Concerns About Research

Unexpressed and underlying concerns about research lingered within the committee throughout the initiation phase. Evidence of this can be found in the nomenclature used to refer to the project. This emphasized the research-derived aspects of its character and de-emphasized practice-based elements. Research committee minutes continued to refer to the project as "the mental health database study" until May 1998, even though it was intended to be only one component of this larger effort and its focus had long since been narrowed to the development of assessment instruments. Furthermore, though it provided the potential for studies, it was not a study. From May

1998 on, it began to be referred to as the "database protocol" or the "risk study," and only late in 1998 was the term "risk project" first used.

Earlier in this chapter, I discussed how these metaphors of a "database" or "study" served to distance the project from the practitioners' direct experience. Although practitioners on the committee formally embraced the risk project as practice enhancement, it was as if a shadow remained about the true nature of the project. Perhaps the idea of enhancing direct practice was abstract for them compared to the easily identifiable uses to which aggregate clinical information could be put for program management. As I will discuss in Chapter IX when I describe the program contact and implementation phases, it is unclear how well practitioners outside of the committee could have understood that its purpose was clinical innovation.

Despite the committee having defined the AdQuest as a practice innovation, concerns about research remained associated with it. This is reflected both in the project's nomenclature and in the pervasive concern that the impact of research methods on clients might create problems in engagement. As I have shown, when the interaction between research principles and practice principles was iterated the project was enhanced but when concerns remained unarticulated the effectiveness of the committee was compromised.

At times underlying and unexpressed concerns about the AdQuest as research may have caused important considerations to be given too little attention. The discussion regarding at which point in the intake process it would be best to introduce the AdQuest focused almost exclusively on the reaction that clients might have and, perhaps because of this, relatively little attention was given to how clinicians might respond.

Without a doubt, this reflects the fact that the practitioners were wary of clinical instruments, as shown by the rejection of RAIs. But it also probably reflects a deeper and unspoken ambivalence about the AdQuest as "research," which in turn might have negative impact of research on clients. Similarly, in considering which key players to include in the design, emphasis was placed on clients and on the psychiatrist, the latter because of the decision to redesign assessment forms. The overriding preoccupation with the impact on clients may well indicate that there were underlying concerns about the project as research. An equal level of concern about the use of instruments as practice tools and the need to pay more attention to overall staff involvement during the design phase might have proven helpful later on at the implementation phase.

By February 1997, it was decided that the AdQuest would be given before the first interview and there was consideration given to developing a second instrument for phone screening to be done at the time of referral. It seemed as if a consensus was now reached that the AdQuest was to be a clinical assessment instrument designed to be completed by all clients prior to the first interview and then reviewed with the client by the practitioner. However, this decision was revisited during the program contract and implementation phases.

Assumptions About Project Design

An explicit assumption made early in the development of the mental health database was that it would consist of a series of interlinked components. This model was intended to develop distinct, staged smaller projects so that participants would have a sense of completion and be provided with a sense of progress and reward. The risk project was to be the first component project. One assumption was that its development would include redesign of the service record. It was assumed that this would lead to redesign of assessment processes and was hoped that this would simplify the work, for practitioners, of recording assessments in the service record. This was seen as a key to building staff enthusiasm. Once this plan was postponed, in order to move the AdQuest forward without further delay, other strategies to build staff support were not explored. This omission created the potential for an underlying, unidentified fault line because the committee continued to operate under the implicit assumption that introducing new assessment methodologies to staff would be relatively smooth.

Intra-Committee Relationships

The committee did not explicitly consider the impact that the risk project would have on its own functioning. Initial enthusiasm for the development of the project as one that would engage the whole committee led to a failure to clarify who would lead it, what level of effort might be required, what amount of committee time it would require, and what its impact on the committee and other projects might be. Perhaps, because the project evolved through a distillation process, the need for a core project group to carry it forward was not identified. Despite the fact that the committee explicitly stated that the project should have manageable components that could be completed in increments, little consideration was given to how to plan and structure it so as to achieve this or to assess what resources might be needed. The initial sketch for the mental health database did not fit well with the style in which the project evolved. While outlining a broad, long-term, program-wide project the committee departed from its implicit of incrementalist "approach," yet as it moved forward it returned to a working style of incrementalism and informality.

Impact of The Research Committee's Intra-Organizational Relationships

Assumptions about the committee's intra-organizational relationships continued unchanged since the pre-rational phase. In taking on the risk project committee members implicitly assumed that the committee was capable of changing program practices. Yet, for the research committee to be effective in doing this - and in bridging direct service practice, management practice and research - its work would have to be well integrated with practice and operational management and with the numerous program areas that comprised the MHP.

During the pre-rational phase and beginning of the initiation phase the committee assumed that it could be effective in meeting this expectation and it engaged in a concerted effort to build and maintain strong connections between practitioners and managers on projects. It also engaged in a parallel effort to maintain ties into the everyday practice. In contrast with these efforts, the connection between the committee's activities and operational management was perhaps assumed to exist, because of my participation as committee co-chair and because another manager was also a committee member.

There is a string of evidence that, during the initiation phase, the committee was effective in bringing together direct service and management practices. The discussions of practice issues that let to consideration of the project, the decision to undertake it, the debates about practices that shaped the AdQuest, and the decision-making process within the committee all strongly support the conclusion that it was able to address issues within a program context. Members were not dichotomizing between clinical practice and overall program development and management practice. The loss of traction that delayed the risk project at the end of the initiation phase may have been an early indicator that these processes were weaker than was evident at the time, especially as the design process took so long. During this time, numerous developments within the program - such as the increasing formalization of teams as a structure and the building of a larger management group - may have contributed to the committee being less integrated into overall organizational life than was assumed to have been the case, but committee members were not aware of this at the time.

Organizational Culture and Practice Technology

Discussions of the issue of consent and confidentiality not only helped develop and refine the AdQuest but revealed a lot about the emphasis on "informality" in the organizational culture. This aspect of the culture was noted but was not discussed at any in any depth within the research committee or project workgroup at the time. Neither did the committee consider the effect this informality might have on the risk project - which was an attempt to introduce greater formality and standardization into assessment processes. Members were excited that the project had led to the discovery that certain organizational practices could be improved. They viewed this discovery as evidence that the risk project might lead to many other practice enhancements. Later on during the implementation phase, as I will describe, I came to view this aspect of the organizational culture as serving a valuable practice function. Informality at the engagement stage can be viewed as giving practitioners the necessary "room" to balance the process of engagement - by establishing a trusting and "private" relationship that meant tolerating a certain level of risk behavior - with the need to explore and respond to client risk behaviors. However, this dynamic was not identified in the initiation stage.

Conclusions: Naming and Framing in the Initiation Phase

It is likely that ambivalence about conducting a broad based "research" project lingered throughout the risk project's design phase. There was evident enthusiasm for the idea of developing an assessment instrument that practitioners would find helpful. A conscious decision had evolved to that an indigenous instrument, particularly designed for the AC context, should be developed. Yet, during the design of the project, heavy emphasis was placed on instrument design and little on its actual in-session use. Once the redesign of assessment forms and intake processes was dropped as a relatively immediate goal, consideration of the practice implications was neglected. It is unclear, even during the program contact and program implementation phases, that staff outside of the research committee fully understood or embraced the risk project's clinical "intention."

Yet there were also clear indications that the project was successfully creating research-practice dialogues that would ultimately augur well for it and for the committee. As it began the risk project, the committee embarked on its first broad, program-wide effort. The decision to do this was shaped by a number of concerns including the desire to create a "database" to be used for both research and program development, and a long-standing desire to understand how better to serve clients. To understand the committee's approach I will again turn to Schon's (1983) concept of the reflective practitioner as someone who uses a process of "naming and framing" (p. 165) to structure uncertain situations into workable problems. How did the committee frame the problem to be addressed?

As it began the initiation phase, the committee decided that rigorously collected, standardized information would serve both research and program needs. From this, the concept of an "MHP database" was developed. The "data" metaphor - with its impersonal research-like language - reveals the committee's uncertainty about research and its relationship to practice. It is an ambivalent metaphor that also suggests the simultaneous embracing and distancing of research. By the end of the initiation phase the committee's struggle to compare and discuss research and practice principles resulted in a project that was designed to enhance engagement and the interpersonal assessment process. Though the committee continued to refer to the project using its database metaphor, the evolution of a new metaphor, i.e., enhancing client engagement, had begun. This suggests that PBR was serving as an effective vehicle for the development of practitioners within the committee and was leading to widening viewpoints regarding practice, program and research.

Chapter VIII. Program Contact:
The Introduction of the AdQuest to MHP Practitioners and Piloting with Clients

1. An Overview of the Chapter

In this chapter I will describe the program contact phase that began in January 1998, when planning was begun for the introduction of the AdQuest to the entire MHP. The phase was bracketed by prolonged delays. The design of the AdQuest had been relatively complete by the fall of 1997 yet planning for program contact did not begin until the years' end. Similarly, implementation was planned to begin in July 1998 but was delayed until the fall of 1998. Figure 6 (page 175) illustrates the time line for the program contact phase.

The task of the program contact phase was framed by committee members as one in which practitioners on the committee must lead and inspire their colleagues by piloting the AdQuest with their own clients. This emphasis resulted in the committee's neglecting to explore how practitioners' practice routines might be affected by the AdQuest. Despite this emphasis on clients, this was the first time in which committee members truly led by mentoring their colleagues, suggesting that they were growing in confidence regarding their competence with PBR.

Section two describes the planning that was done for introduction of the AdQuest to staff and carefully selected clients. The decision of the committee to demonstrate that the AdQuest would be a helpful tool led to the goal of program contact being defined as honing the AdQuest and planning for its implementation rather than exploring practice implications and practitioners' questions.

The period of intense activity that began in March 1998, during which several simultaneous processes were initiated, is described in section three. These processes included the testing of the AdQuest with long term clients and the use of focus group methodology to refine the AdQuest, and the formal introduction of the project to staff. That the committee "naturally" used a Participatory Action Research (PAR) approach reveals a culture in which clients were viewed as a community and valued their right to self-determination was valued. The piloting process led to the determination to develop a family assessment instrument, to be completed by parents, to complement the AdQuest.

After piloting the AdQuest with their own clients, committee members formally introduced the AdQuest to staff in two staff meetings. In its first meeting, in March 1998, the committee initially defined the project as research-driven, a throwback to the initial concept of a "database." Even as its clinical uses were explored in a second meeting, which occurred in April 1998, the implications for assessment practices were not explored. The primary issues that were addressed related to clients' comfort with the AdQuest not that of practitioners.

Section four describes the period between the initial introduction of the AdQuest to clients and practitioners and prior to implementation. This resulted from the decision that implementation should await the design of a family questionnaire and from logistical problems in implementing, such as a lack of space. During this period the FamQuest was designed. Section five describes this design process which led to

Figure 6: Timelines for the Program Contact Phase

January 1998 to October 1998

THE PROGRAM CONTACT PHASE

☐ 1998

- ◊ January 1998, committee plans for contact with clients & practitioners
  - ○ Committee frames the "problem of contact" as the need to allay practitioners fears that "research" will disrupt engagement
- ◊ Initiation planned for July 1998

- ◊ Client contact
  - ○ March '98, The AdQuest is subjected to focus group methodology
  - ○ March to April'98 - the AdQuest is "tested" with long- terms clients followed by research committee members

- ◊ Practitioner contact
  - ○ March '98, a first staff meeting introduces the AdQuest- but presentation emphasizes the "research" aspects of the project
  - ○ April'98 - a second staff meeting, the AdQuest is defined as an engagement and assessment tool
  - ○ Thoughout, the focus is on clients not practitioners & practice
  - ○ The "problem of contact" is framed as the need to allay practitioners fears of disruption to to engagement
- ◊ Initiation planned for July 1998

- ◊ May '98 FamQuest design begins
  - ○ Committtee decides not to proceed without a family assessment instrument
  - ○ June '98, FamQuest design group formed
  - ○ July '98, FamQuest design initiated, AdQuest implementation postponed until September

- ◊ September '98, dissension in FamQuest design group, will a family asseessment instrument compromise the MHP's adolescent- centered care model?

- ◊ Implementation postponed until November '98

- ◊ October '98, the FamQuest is complete
- ◊ A hurried plan is made for implementation

- ◊ Conflicts emerge in the research committee as it plans the risk project implementation

☐ 1998

debates over whether a family assessment instrument might lead to a shift in agency focus away from adolescent-centered care. Eventually the FamQuest was defined as an adolescent-centered instrument that would assess recent family life events and parent/s' assessment of their adolescent's risks, coping skills and problems.

In the fall of 1998 conflicts began to arise in the research committee regarding concern about the committee's effectiveness, and section seven describes how they first emerged. Though concerns were about the slow pace of the committee's work were shared by its members, divisions arose as to the causes of this. Though these issues were not clarified until the implementation phase, and are discussed in fully in Chapter IX, they caused me to reconsider my co-leadership of the research committee.

The chapter ends, in section eight, with an analysis of the program contact phase. This begins with an iteration of the explicit and the implicit assumptions that were at work in the research committee. In particular there was an assumption that the committee needed to reassure practitioners about the impact of the project on clients and this shaped the way the committee viewed the tasks of program contact.

The program contact phase also seems characterized by ambiguity in the way the risk project was defined for practitioners outside the committee. The initial presentation to staff focused on research and program development goals and on the metaphor of a "database." I describe why this cold and impersonal metaphor distanced practitioners from considering how practices might be influenced by the AdQuest, perhaps revealing an organizational culture that was as threatened by clinical innovation as by research. I conclude that, despite the problem that a dialogue did not occur about the risk project's practice implications and despite the informality of the committee's relationship to the MHP, there is evidence that the committee was becoming more comfortable with PBR and its own competencies.

2. Planning for The Program Contact Phase:

What was Anticipated?

Tripodi et al. (1978), in describing the Differential Program Evaluation Model, defines the goal of the "program contact phase" as contact with program beneficiaries to secure their participation in the service innovation. This suggests that evaluation of the phase should be focused on measuring the success in achieving this objective. Although the ultimate purpose of the risk project was to benefit clients, its goal of enhancing service effectiveness was to be pursued through innovations in the service approach. The beneficiaries of the risk project - a technological innovation - were to be the MHP's practitioners and managers. In Tripodi's view therefore, the work of the contact phase should have been focused on informing them about the project, addressing their concerns and enlisting their goodwill. As it began planning for contact, in February 1998, this was the committee's intention. However as I will show, the committee became increasingly focused on making contact with clients, honing the AdQuest and, in this way, alleviating the concerns that other practitioners were thought to have.

Planning for the program contact phase began in February 1998 and continued into early March during a period of high expectations and much activity. Pressed to start implementation after many delays, the committee set an ambitious schedule. Planning for the phase was driven, not by an analysis of tasks that would need to be completed, but by the selection of a date for implementation. Concerned that implementation might initially disrupt services the committee picked July 1998 as the implementation date. Customarily, July and August brought a drastic reduction in referrals of new clients in contrast to the high volume seen throughout the remainder of the year. Implementation in July and August would allow a greater effort to be used to iron out any small, unanticipated problems and would be potentially less disruptive.

The committee began to consider what should be done to introduce the AdQuest to staff and decided to use two staff meetings in March and April to begin this process. However, even as it began to consider how best to create a dialogue with program staff, it simultaneously began to plan for piloting and testing the AdQuest with clients. This quickly became the preoccupation. Concerns about the reactions of practitioners were framed as relating to their fears that the AdQuest might have a negative effect on client engagement not in terms of its impact on their practices. Planning focused on allaying these fears, real or imagined, through a strategy of testing the AdQuest with clients before introducing it to program staff.

Testing the AdQuest would be done in two ways: (1) It would be given to long-term clients being followed clinically by practitioners from the research committee, (2) An adolescent focus group would review it. Research committee meetings were used to create protocols for these processes. As a result, committee meetings in February and March of 1998 were used almost exclusively to discuss the risk project. As I will discuss in the next chapter, this use of committee time resulted in tensions that emerged openly between committee members in the fall of 1998.

Although the decision to test the AdQuest with an adolescent focus group and with long-term clients was initially intended to help secure program staff acceptance of the project, planning became focused on using the process to hone the instrument, to see how long it took clients to complete, and to assess its comprehensibility. By using the focus group methodology the committee borrowed from Participatory Action Research (PAR) (Sarri & Sarri, 1992) and Participatory Evaluation (PE) (Patton, 1990). In these approaches target populations are involved in the design of research studies. This method was chosen to strengthen the AdQuest and to legitimize it in the face of concerns over the reactions of MHP practitioners. PAR / PE methodology is most commonly used to foster collaboration in community projects so as to jointly solve community problems (Patton, 1991). That elements of PAR / PE were developed "naturally" and intuitively by the research committee is telling. The AC culture reflected a deep concern for the community of adolescents and a reluctance to "impose" research upon this community. This parallels the committee's refusal to impose research upon other MHP practitioners.

3. The AdQuest is Introduced to Clients and Practitioners

Between March and April 1998 the AdQuest was introduced first to an adolescent focus group, then to long-term clients and, last, to the MHP practitioners.

Focus Group Methodology: March 1998

In March 1998, the research committee conducted focus groups to obtain feedback on the AdQuest. Two goals for this process were evident. First it was to ensure that the finished instrument would be relevant, comprehensive, and comprehensible to clients. Second, it should generate acceptance of the AdQuest by staff by demonstrating that it was legitimate. Research committee members still feared that the questionnaire might be overly intrusive, that its language might be too "clinical," and that clients and staff might view it as cold and impersonal.

Six adolescents were recruited from among adolescents who were members of the Adolescent Center's Peer Program. These were clients who had received a sixty-hour training module in adolescent health issues, and who provided supervised outreach and health education to other adolescents. As participants in the Peer Program, they received supervision, supportive counseling and stipends, and worked with other adolescents in the AC and in community settings. They were between sixteen and twenty-one years old. A health educator from the peer program staff was chosen by that staff to join the group.

The focus group was run by a clinical psychologist - who was a specialist in group work but not a member of the research committee. He was assisted by two program assistants, i.e., nonprofessional staff who were assigned roles in the group process. One assistant recorded the session, on audiotape and in writing. The second monitored emerging issues and themes to ensure that they were explored by the group leader. The group was oriented to the focus group process and then asked to comment on the content, range, wording, appropriateness and overall effectiveness of the AdQuest.

Feedback from the focus group was presented to the committee at the end of March. It provided a rich commentary on the instrument specifically and on the risk project in general. The first issue the focus group had discussed related to client engagement. Having feared that the group would see the AdQuest as intruding too much into personal issues, before a professional relationship was formed, the committee was encouraged by the feedback it received. Rather than being concerned about intrusiveness, focus group members thought that the AdQuest did not go far enough in fully exploring the range of issues faced by AC clients. The group recommended that asking for more specific detail about client behaviors, attitudes, knowledge-levels, and beliefs, would help new clients feel better understood. The AdQuest was, in their view, too impersonal not because it was an instrument but because it was too general.

The group generated a list of more than 80 additional questions that it recommended be added to the existing 80 items on the AdQuest. These can be classified as one of two types - forced-choice questions, that sought detailed information about client experiences or behaviors, and open ended exploratory questions. About forty additions of the former type were suggested. For example, the focus group suggested distinguishing between what they termed "social drug use - when you go to clubs" and "avid drug use." Another example related to the question "If you are not working, do you want to work?" The group suggested that this be supplemented by the additional question: "Have you ever tried working?" The group also suggested that many forced choice questions be supplemented with open ended exploratory questions seeking further elaboration. Examples regarding work included: "Why do you want to work?" and "Why are you not working?" These suggestions were made for almost every item on the AdQuest. They did not recommend that any other questions should be dropped.

The focus group also suggested that "more personal wording" be used on introductions to each section of the AdQuest to help new clients feel welcomed and understood. These sections, it was suggested, should not be problem-focused. This recommendation was quickly followed.

There was additional, though contradictory, feedback about engagement issues. While the group was unified in stating that project was worthwhile and should be pursued - they had not been asked about this - there were indications of ambivalence about the introduction of instruments in mental health assessment. They suggested that the AdQuest would enhance discussion and engagement, and clearly supported the use of risk assessment instruments. There were commonly used by the Peer Program. However, there were differences regarding at which point in the initial engagement process instruments should be introduced to clients. One comment was "don't use it to do the social worker's work for her." Some participants felt that the AdQuest should be it introduced during the first interview only after there has been some discussion of the AC and its services. The group leader's attempt to clarify this issue led to identification of an underlying concern that instruments not replace direct, face-to-face services.

Suggestions were made regarding the wording of specific questions. The focus group thought that many questions were phrased "negatively" and were problem-focused and that client strengths were not adequately explored. For example, a question asked about "cutting" classes - the language that practitioners felt was the parlance of clients - was considered negative. In another instance, they felt that asking about "problems on the job" should be replaced by the words "experience on the job." Other suggestions were made, and followed, regarding the sequence of sections or questions. For example, a section on work was shifted to follow the one on school that originally preceded it.

The focus group felt strongly that the AdQuest should be supplemented by a questionnaire that explored parallel issues with parents. Initially, the reason given was that, from a practical point of view, parents would need to be occupied so that adolescent clients could complete the AdQuest privately and without intrusion. This view had also arisen in the research committee. Further exploration led the group to state that many adolescent problems were embedded in family problems and that a failure to properly define some problems as family problems, or parental problems, placed too much emphasis and blame on adolescents. Many adolescents, they said, might not need therapy, in contrast to their parents: "parents often do." The group's perspective was that adolescents would trust better the service being offered, and feel most understood, if they could see that practitioners would equally assess both parent and client contributions to the presenting problems.

Revisions were now made to the AdQuest and many questions were reworded and revised. The focus group's recommendations that additional questions be used to obtain greater specificity were followed only in a very few instances - for instance better distinction between hard and soft drugs. Most suggestions for additions were not followed, for three reasons. (1) The research committee was concerned that the overall length of the AdQuest should not be greater than twenty minutes - so as not to extend the first encounter too greatly. (2) The committee wanted to avoid open ended qualitative questions. The experience with the satisfaction / marketing survey conducted in 1995 - and described in Chapter VIII - was that open-ended, questions generated few responses and seemed to confuse new clients. The committee viewed these follow-up questions as the role of the intake interviewer. (3) The focus group recommendations, that the AdQuest should elicit much greater detail, paralleled the approach that the research committee had initially used and abandoned - that of a risk inventory. A decision was made that, overall, the AdQuest should not be made more lengthy and specific. However, the recommendations for a family or parent questionnaire were taken to heart. In meetings in April the committee began to consider the development of a family questionnaire - the instrument that became the FamQuest.

The AdQuest is Piloted With Long-Term Clients - March to April 1998

The research committee decided that a second pilot of the AdQuest should be done with a selection of cases chosen from research committee members' caseloads. The committee reasoned that this was the best way to obtain first-hand experience of the issues that might be faced in implementation, including logistical issues - such as the length of time that a client might take to complete the instrument. Of deeper concern was how the AdQuest would be received by adolescents, an issue not put to rest by the focus group feedback. Committee members viewed the peer counselors as a relatively sophisticated group, when compared to the general client-population. Their training and experience with risk assessment tools and surveys might make them more likely than new clients or practitioners to view the AdQuest in a positive light. Practitioners on the committee felt that first-hand experience would enable them to directly address any concerns raised when the project was presented to staff.

Seven adolescents were selected by research committee members, all but one - who was given the AdQuest after his second intake interview - had been receiving treatment for three months or more. Protocols for the introduction of the AdQuest to the clients and for debriefing interviews were created in committee meetings. These discussed the purpose of the questionnaire, and why the particular client had been selected, and confidentiality - providing a template for what would eventually be said to new clients. A qualitative interview guide was developed to explore the clients' experiences in completing the AdQuest. The guide explored client responses to the AdQuest. Areas covered included its comprehensibility, the currency of its terminology - as practitioners pointed out that terms for various common behaviors and for drugs changed over time - and the appropriateness, comprehensiveness, and intrusiveness of the content. Clients were also asked whether there were subject areas that they felt were missing or were inadequately explored.

The results of the pilot were seen by committee members as overwhelmingly positive and the practitioners who had conducted it were enthusiastic and excited about their experiences exploring their clients' responses. As I will describe, respondents had given both general feedback on the AdQuest and specific feedback on the format of questions and coverage of issues.

Only one adolescent was unwilling to answer the survey in writing telling his therapist "you know everything about me anyway." The therapist stated that, despite a seeming lack of trust from this very "streetwise" client, the client had been willing to discuss all of the issues explored by the AdQuest openly but had balked at putting any responses in writing - "in the permanent record." Discussion of this concept of a permanent record - that practitioners on the committee said was commonly held by clients - spurred a serious discussion of the agency practices. Committee members concluded that the service record was often not discussed and clients were ill-informed about its use, the limits of its confidentiality, and their rights in regard to it.

All but one client who had participated stated that completing the AdQuest, and discussing their responses with their therapist, had been a positive experience for them and that similar processes would be helpful to new clients. Three pointed out that practitioners should explain to new clients how the instrument would be used and how it could help their treatment. These respondents reported feeling comfortable with, and interested in, the survey. One indicated that it made him "think about things that he had not thought of before," and he later used this experience to open up new areas in treatment with his therapist.

Two respondents, a fourteen and a sixteen-year-old, felt that the issue of work was not adequately explored and indicated that they would like help in finding work. This resulted in the addition of a question regarding the issue that led to a surprise for practitioners in the committee when data from the AdQuest pilot with 50 new clients were analyzed. As I will show in the next chapter, this proved to be a widespread aspiration, yet was an area previously ignored in the Adolescent Center's assessment process.

All respondents in this testing process said that the AdQuest should be completed in a separate room from parents. Paralleling the feedback from the focus group, two respondents felt that parents should be asked similar questions, indicating that sometimes parents were the troubled ones. For committee members this underscored the feeling that the FamQuest should be developed as soon as possible.

Three respondents pointed out that forced choice questions were problematic as adolescents might "not know" how to answer as they might be unsure about their experiences or feelings. Committee members examined when "don't know" might be the desired response, as it might be clinically informative. This practice perspective was in sharp contrast to the research canon that a "don't know" response results from a question-failure and is useless in data analysis. "Don't know" responses to some questions - such as "Have you ever been forced to have sex when you did not want to?" or "Has anyone ever touched you in a way that you did not want them to?" - might indicate an adolescent's uncertainty about what he or she should tolerate as acceptable behavior. It might reveal an adolescent's lack of knowledge or efficacy and empowerment to make decisions that were healthy or safe. "Don't know" responses to such questions might be clinically powerful as they might open up avenues for exploration and intervention, even if from a research point of view they might seem to generate limited information in terms of specific situations, experiences or behaviors.

The pilot did much more than put the direct service workers on the committee at ease. Each was greatly surprised by the clinical discoveries he or she had made, even with long term clients. Some of these discoveries took the form of new areas for discussion that, though not dramatic, opened up possibilities that had not been explored. These led to some practitioners feeling that they had gotten to know the client in a more holistic way.

Such "small" discoveries included discussions of the client's attitudes that affected future possibilities such as work. One practitioner, reported feeling excited that the session had led to discussions of the client's world that, though not directly related to the presenting problems, helped him understand his client differently. The practitioner, having felt that the presenting problem had been addressed and that the treatment had recently become static, stated "I can't wait to see where we go with this." Other discoveries, though they did not take the form of dramatic disclosures, related to core issues in the client's experiences that were directly related to issues being discussed in treatment. For example, three clients revealed that they had questions or issues related to ethnic identity.

Other discoveries were very dramatic. One depressed client revealed having been the victim of racial taunts that had made her "feel ugly." Experiences of racism had never been included in the agency's routine psychosocial assessment and are not, in my own experience, usually explored in mental health settings.

One practitioner discovered that a sixteen-year-old, whom she had followed for over a year and considered high-functioning, had a serious and persistent alcohol problem. Though this therapist had known about past alcohol use it was thought to have been a relatively minor problem that had been resolved. The practitioner was able to change the intervention plan to address this urgent need.

Another practitioner, with expertise in adolescent sexual abuse and incest, used an opportunity created by the AdQuest to discover histories of childhood sexual abuse and recent trauma in her fourteen-year-old client. She had followed this client for more than six months and had previously taken a thorough psychosocial history in which sexual abuse was denied. This had emerged through a convoluted process. The client asked for clarification regarding the meaning of the question "Have you ever been forced to have sex when you did not want to?" After clarification was given, the patient asked several veiled questions about confidentiality, finally asking directly, "What are you going to tell my mother about what I tell you?" After confidentiality was discussed, the client revealed that she had recently been threatened with a gun by a police officer. Further discussion resulted in the revelation that, as a child, she been sexually abused on several occasions by an adult family member.

These experiences strongly suggested to committee members that AdQuest might be a highly effective clinical tool when used in conjunction with the clinical interview, with both long-term and new clients. Practitioners in the research committee concluded that the AdQuest could facilitate therapeutic processes.

The Introduction of the AdQuest to staff: March and April 1998

The risk project and the AdQuest were formally introduced to the Mental Health Program staff in a staff meeting in March 1998. First, the AdQuest was circulated and discussed with team leaders in the MHP's operational management meetings and then circulated to the program staff prior to the March meeting. A second meeting was held for staff in-service training in April.

By the time it the first formal presentation of the risk project to staff, in March 1998, its shape had evolved from the original, broad framework of the "mental health database" into the AdQuest. Despite this evolution, when the project was presented to MHP staff there were contradictions in the stated goals that went unnoticed at the time. The formal goals of the first meeting with the MHP staff were consistent with the framework for program contact outlined by Tripodi et al. (1978). Staff were told that the objectives of the session related to the research committee "seeking your help and feedback in completing this instrument [the AdQuest] *and thinking about how to implement it in our intake system*." However, as the project was presented, the original idea of the mental health database shaped the presentation of its goals, rationale, and description. Thus, the emphasis was placed on program development and research, not on practice innovation.

Specifically in March 1998, MHP staff were presented with the following project goals, originally formulated in June 1996:

> (1) To provide baseline information that we need: for appropriate clinical care, including identifying high risk kids; for longitudinal study of trends and risks; to understand client risks, resiliencies and expectations of our service.

> (2) Programmatically to: develop assessments based on uniform standards and comprehensive assessment, including identification of risks, serve to provide database for other research studies; assist in program development; to assist in the preservation / expansion of grant and other funding for program through the systematic gathering of data on our client profile.

This March staff meeting focused on the describing the risk project as one step in a larger process that might include the development of additional tools, a change in service recording practices, and the development of research studies. Research committee members presented their experiences piloting the AdQuest and this led to a discussion of various practitioners' experiences in settings where assessment tools were used. In the view of committee members, this introductory meeting went well and plans were made to follow up with a meeting in April at which there would be a focus on implementation issues.

During the April 1998 staff meeting the goals of the project were presented to staff as follows (1) "to enhance the organization capacity by identifying risk factors," and (2) "from a patient's perspective, to get better information on whom our clients are, what their needs are and, therefore, service them better."

This second meeting was dominated by concerns that clients should be comfortable with the AdQuest. Practitioners did not raise concerns either about their own comfort or how using instruments might influence on the assessment process. There were three main areas of discussion. (1) Practitioners had questions regarding how confidentiality and consent would be handled. (2) Questions were raised about what was the most desirable point in the assessment process for the introduction of the AdQuest. (3) Practitioners had suggestions regarding the content of the AdQuest and ways it might be improved.

The issues surrounding confidentiality and client consent were discussed after two questions arose. Should confidentiality be discussed before clients filled out the AdQuest? And, should clients be asked for consent and, if it were not given, be allowed to opt out of completing the questionnaire. These questions and the discussion that followed paralleled the questions faced by the committee and the decision-making process that it had undergone during the program initiation phase. Discussions of confidentiality revealed variations in what was emphasized and discussed with clients, and when such discussions occurred. Similarly, discussions of consent - and the initial suggestion by one practitioner that adolescents should be given the choice of filling out the AdQuest - led to clarification of the purpose of the AdQuest - as an engagement tool and not a research tool - and discussion of adolescents' attitudes toward treatment, and the too-common experience of client hesitancy about engaging. The committee concluded that staff were in agreement that all clients should complete the AdQuest.

Discussions of the timing of the introduction of the AdQuest also appeared related to ensuring that clients were comfortable and addressing very practical problems that might arise during intakes. For example the staff discussed how to ensure that clients who may not read well could be identified and helped. Another concern was that younger adolescents should be comfortable with the language and that it should be understandable to them. Should they be able to take it home? Should they be helped by their intake worker? Should they fill it out in advance of the interview? Some practitioners in the group described their experiences with questionnaires conducted before intake in other adolescent-serving agencies. Research committee members described the pilot experience. In a process parallel to that experienced in the research committee, practitioners in the staff sessions generated the view that giving the AdQuest to clients prior to intake was preferable from the point of view of data gathering. It would, in the words of the MHP practitioners "result in better data." Waiting until later would result in lost opportunities to better-understand clients who dropped out of services.

In the last chapter, I described how the descriptor "database" had persisted in the committee long after the risk project had been defined as a clinical innovation. The fact that the term data was being used now to describe information that, were it gathered by interpersonal means, might more-accurately be called "clinical information." Furthermore, the concern shown by practitioners about getting "good data," also reflects the continued identification of the AdQuest with research.

Staff also identified areas that they felt were missing from the AdQuest or that should be explored in more depth. These included questions related to spiritual beliefs and religious practices. One view was that exploring each client's spiritual belief would help clients feel understood. Another view was that attendance at religious services was thought to be an indicator of reduced risk and family strength. One practitioner mentioned a recent school shooting that had involved adolescent perpetrators and a concern, raised in the media, that lack of involvement of "concerned adults" in an adolescent's life might be a risk factor. Because of these discussions, questions were added about religious practices and spiritual beliefs. The committee's resolve to develop a family questionnaire was also strengthened so that comparisons might later be done between risk behaviors and the congruence between the adolescent's assessment of his or her own risks and the parent's assessment. Members felt that these experiences had helped the overall staff accept the project, at least initially.

4. Implementation Delays

Although implementation of the AdQuest in the intake practice had been planned to begin in July 1998, the decision was first made to delay implementation until mid-September 1998. A number of factors lead to a further delay until November. These included recognition that there should be a family assessment instrument to complement the AdQuest, logistical problems with space and support staff, and dissension in the research committee.

The need for a family assessment tool had been considered for some months but feedback from the focus group, from the pilot and from staff, indicated that it was imperative. One very practical reason that was articulated by practitioners as to delay implementation of the AdQuest until the family questionnaire was completed, was to make implementation easier by occupying parents while their adolescent filled out the AdQuest in another room. However, the committee also took the advice of the focus group to heart - adolescents should feel that their assessment was being done in a family context. Other factors which contributed to the delay were mainly logistical ones, including a lack of space and the need for support staff.

Practitioners on the research committee had initially felt very strongly that the AdQuest should be given to clients by the practitioner conducting their assessment. This view had become entrenched during the design of the AdQuest, in large part because practitioners on the committee considered it essential to ensure that all practitioners were closely involved in monitoring implementation so that they could intervene if any concerns were to arise over confidentiality, in understanding the questions, or in reaction to the context. After piloting the AdQuest, practitioners in the committee made a sudden departure from this view. They became increasingly concerned that the risk project should be designed to ultimately reduce the overall burden for practitioners and cause the least disruption possible. They now decided that a program assistant should introduce the AdQuest to clients as they arrived for their first appointment.

In July 1998 three research committee members prepared an introductory statement to be made to families and individual clients about the AdQuest and developed protocols for implementation. A program assistant, who was also a research committee member, was trained for this purpose. Adolescent clients would be seated in a conference room to complete the questionnaire. However, in September this plan was again delayed due to a lack of space caused by the expansion of group services. This highlighted the lack of formal coordination between the research committee and other development activities. The delay in starting implementation was exacerbated by the need to hire into vacant support staff lines.

5. Design of a Family Questionnaire: The FamQuest:

When the risk project first took shape in late 1996, assessment of family factors that might contribute to adolescent risk had been considered, as I described in Chapter VII. Then a decision had been made that this dimension of risk assessment would be treated as distinct project component that could be initiated later. As the AdQuest evolved, from a risk inventory into a more holistic tool, so did the idea that it should be used to assess the adolescent's perspective on his or her family situation. This led to the inclusion of questions asking each adolescent about how concerned his or her family was about several adolescent risks and coping behaviors. By April 1998 the opinion of the March focus group - that called for a family assessment questionnaire -and the responses from staff meetings, contributed to the conclusion that the AdQuest and a parent questionnaire should be treated as one project. Development of a complementary parent questionnaire that would be implemented at the same time as the AdQuest seemed increasingly necessary.

By May 1998, a small group of research committee members, two with expertise in family therapy, was formed to begin this work. One practitioner had been hired specifically to help in strengthening family therapy as a modality and to help develop services for parents. The parent questionnaire, or FamQuest, as it came to be called, was completed in November 1998. In comparison to the AdQuest, the FamQuest design process took place much faster. However, there were parallels between the two development processes in that clarification of the purpose of the instrument was the most difficult and time-consuming step.

Disagreements about what the purpose of the FamQuest should be emerged in the FamQuest design group as it began its work in June, and stalled its progress. Three components of the FamQuest were being considered. (1) One component was a set of questions that would be complementary to those on the AdQuest, asking about the adolescent child's behaviors, concerns and coping. There was a consensus that this should be developed. (2) The second component proposed was a family events scale that would ascertain recent family-life events. There was a consensus that this should be developed as it would provide a way to obtain essential information about stressful events rigorously and efficiently. Many practitioners did not routinely explore this aspect of family history at intake, either for lack of time or due to a focus on other pressing concerns. (3) The third proposed component was a tool to assess family functioning, family problems, and the quality of family relationships. This was the most controversial proposal and it led to a stalemate within the FamQuest design group.

This stalemate was brought back to the research committee. As the proposed components were reviewed, two different views of the FamQuest's purpose emerged. One view was that it should provide a perspective from parents about their adolescent's functioning, behaviors, worries and risks, i.e., that it remain adolescent-focused. An alternative view was that the FamQuest should serve as a diagnostic tool to help assess overall family functioning, family relationships and the parental coping skills. Proponents of the "diagnostic" view were those practitioners most interested in creating a family therapy program within the MHP. However, some practitioners on the research committee were concerned that the focus of the FamQuest should be the individual adolescent, not the family, due to several concerns.

First, they were concerned about the MHP's capacity to address the large number of family issues that might become routinely identified if every parent who came at intake was given a family functioning "diagnostic tool." About 50% of all clients came with a parent for the first interview, and more than 60% of clients less than eighteen years of age. As one practitioner said, "[the FamQuest] might raise problems that we are not equipped to address." This issue related to a second concern. What effect would a routine assessment of family functioning have on the MHP's focus? This concern was framed by a practitioner with the question: "Who is the client here?" Practitioners who expressed the adolescent-focused viewpoint were not unconcerned about family problems, nor did they reject family therapy as a viable modality for the MHP. Many of those who voiced this perspective utilized family therapy in their work and, at times, worked with the family as their focus. They voiced the concern that a family-focused assessment instrument would lead to a shift in emphasis overall from adolescents to families and would compromise the adolescent-oriented mission of the AC. A family focus would create practice dilemmas, for instance, regarding client confidentiality that might make it impossible to provide adolescent-centered care.

Agreement was reached that the FamQuest should proceed - at this time - with only the first two components and would remain focused on adolescents. Development of a component to assess family functioning would divert energy and resources from the risk project and would raise broad philosophical issues that would also divert attention from the work to be done. The committee acknowledged the value of an instrument that might assess family functioning for use with families who were engaging in family therapy. It was thought that this could be developed later for this subset of clients but should not routinely be given to all parents. It was established that the FamQuest would be a combination of a family life-events scale and a parent assessment of his or her adolescent. A decision was made that the FamQuest should have questions that were complementary to those on the AdQuest, keeping the adolescent's experiences, behaviors and concerns at center-stage. Figure 7 (page 199) compares a small sample of the questions asked of parents on the FamQuest with complementary items on the AdQuest.

Figure 7: Complementarities between the AdQuest and the FamQuest

Samples of FamQuest questions that asked parent's overall level of concern (see Appendix D for complete FamQuest):

11. How often do you worry about your child's sexual behavior?

Always Often Sometimes Rarely Never

14. How often do you worry about your son/daughter's friends?

Always Often Sometimes Rarely Never

15. How do you feel that your child is doing in his / her personal life?

Very poorly Poorly Average Well Very well

Samples of AdQuest questions that asked the adolescent's overall level of concern, examples are taken from AdQuest sections on "sexuality" and "personal life" (See complete AdQuest in Appendix C):

54 Do your friends or family members ever worry about your sexual behavior? Yes___ No___ Don't Know___

55 When it comes to sex, your body and birth control how would you say you are doing?

Very Poor Poor Average Well Very well

66 Do you have any worries about your friends or associates? Yes ___ No ___

67 Do your family members ever worry about your friendships? Yes ___ No ___ Don't Know___

68 In general, when it comes to friendships how would you say you are doing?

Very Poor Poor Average Well Very well

6. Research Committee Processes in the Fall of 1998: New Conflicts Emerge

During October and November of 1998, as the research committee was discussing the FamQuest, and planning the year ahead, conflict began to emerge in its meetings. These conflicts appear to have been generated by the risk project as well as broader issues, to do with the relationship of the research committee to the overall program.

Committee minutes and project notes from mid-October, 1998, show numerous fault lines running between committee subsystems, suggesting that the group was becoming more fragmented. There were strains between the committee leadership and other members and between some direct practitioners and managers, and between those who had been most actively working on projects and those who were least active in project work. There were also tensions between those who were currently most involved in the risk project and other committee members. First arising in October 1998, these issues took time to become well defined and were not formally addressed until December 1998. This was after implementation of the risk project had begun.

As I will describe more fully in Chapter IX, discussion of the issues that had given rise to these conflicts occupied large amounts of committee time up until March 1999 when the committee undertook to reexamine its structure, purpose, leadership, resources, and relationship to other program activities. The first signs of strain emerged as the program contact phase came to an end and implementation began. As these strains reflected problems in the risk project, as well as the research committee, they also affected the thinking about implementation. I will briefly describe the issues as they appeared to the committee in the early fall of 1998.

In October 1998 my committee co-leader and I became concerned that projects were moving forward too slowly with little sense of completion. It had seemed difficult to get committee members to bring their projects to the table. We believed that the risk project had become a convenient topic for meetings and we were concerned that other projects appeared to be stuck. Another concern that we shared was that committee members seemed to be carrying projects forward single-handedly with too little connection between projects and other practice activities.

Many members expressed feeling that their projects were struggling due to a lack of support in the form of expertise, consultation, technical assistance and support staff availability for word processing, data entry and so on. Some thought that the risk project was dominating the committee's activities and taking time and resources away from other projects.

Two practitioners on the committee, who had made a significant contribution to the risk project, expressed the feeling it had become "administration's" project and that practitioners were being left out as the project moved forward. These members thought that the risk project and the psychosocial sequella to violence study were receiving resources, in the form of technical assistance clerical support and data-entry, while others projects were not. They raised the question: Were projects that were being led by administrators receiving support, while practitioner-led projects were not? This perception may have been heightened by the fact that preparation for implementation of the risk project led me to recognize the overall need for greater levels of technical assistance and support, for training in statistical software, support in the form of clerical assistant time for data entry, and so on.

These issues increasingly emerged during the implementation phase when the committee leadership made a concerted effort to address them, to improve resource availability, and to restructure the committee, and I will return to them in the following chapter. However, they had a significant impact as plans were being made for the risk project implementation.

7. Taking the Program's Pulse: Feedback from MHP Staff

As the project awaited implementation, a key question that I considered was, how was the risk project viewed by the MHP practitioners overall? After conflicts emerged within the research committee, I felt disquieted. Questions arose in my mind as to how much these conflicts reflected the concerns of staff beyond the research committee. Were there unexpressed concerns about the use of instruments? Were, there other issues that staff might have regarding the risk project?

Between the second formal presentation to staff in April 1998 and the start of implementation in November 1998, MHP staff were updated regarding the progress made and delays faced. As protocols for discussing confidentiality and the FamQuest were developed, they were circulated. Progress was also reported in operational management meetings. Overall, little response came back from staff in supervision groups, team meetings or staff meetings. The only interpretation that emerged in the research committee - one that seemed to have been embraced by many members - was that the project needed to move forward to become concrete and real to MHP staff, and that for the present it was "out of sight and out of mind." There were no formal efforts to further involve practitioners outside of the committee in the project, at this time, so this is not surprising. This apparent lack of concern and is congruent with observations made by others (Adler et al, 1993; Marsh, 1983; Pruet et al, 1991; Sidell et al, 1995; Williams & Hoppes, 1988) that practitioners, particularly in health care settings, must be highly task-focused and concerned with the concrete and immediate demands of their service area.

One indication of some concern occurred in mid-September when two staff made known, first informally and later in meeting with me, their dissatisfaction about their fall 1998 assignments, made after expansion of a school-based, vocational mentoring service. They aired the view that this "non-clinical" assignment was less worthy than other clinical or programmatic assignments. Further exploration revealed concern about whether the MHP was "changing direction" toward the favoring of research and program development and the "devaluation" of direct clinical services.

Another of my concerns was related to my involvement in this dissertation study and whether practitioners would view my involvement in the risk project as having an ulterior motive. If so, would this jeopardize the risk project? In March 1998, I had decided that my dissertation study would be a process evaluation of the development of the risk project. As this idea evolved, I had discussed my ongoing plans in the research committee and I had openly discussed it with staff, in the committee and individually. In October of 1998, I announced in the committee that I had submitted my dissertation proposal and was to meet with my dissertation committee. I became concerned about how my study might be viewed, when a colleague mentioned that there were tensions within the committee about dissertation work. As I will describe in Chapter IX, these strains were to emerge openly at the year-end. The airing of concerns about resource allocation within the research committee led me to be more concerned. In a follow-up discussion with the colleague who had approached me I was told that some staff were concerned that the risk project work was being done for my dissertation. I was advised to clarify the nature of my dissertation for the committee and to make clear the distinction between it and the risk project. Open exploration of this issue later, in the committee, did not reveal whether this was in fact the case and other issues appeared considerably more potent. As it was unclear to me whether committee members would feel free to discuss this, and similar issues openly, I began to consider stepping out co-chairing the research committee.

What would the implications of my stepping out of this role be? Although I was aware that committee members might interpret it to mean that I was less invested in the committee, I believed that it would, reinforce my formal authority role. I would be shifting to a greater reliance on bureaucratic authority and legitimation of the committee structure.

8. An Analysis of the Program Contact Phase

Tripodi et al. (1978) define the primary task of the program contact phase as contact with program beneficiaries to secure their involvement in the service innovation, by creating a willingness to participate. Evaluation of the phase should be focused on the success in achieving this objective. In contrast to the initiation phase, planning for the contact phase involved a more rational process. The committee started the program contact phase with the intention of securing staff participation and support, yet as the phase evolved most of its effort work expended focused on piloting the AdQuest with clients, honing it, and developing the FamQuest. The assumption that led to this process was that the overriding concern of practitioners outside the committee was not the impact of it on their own practice methodologies but the impact on client engagement. To the committee, it followed that the most effective way to address this issue was by showing that instruments could help clients and would not harm them. As a result, though considerable planning was done during this phase its focus was on planning piloting processes and using these processes to refine the AdQuest. The decision that the FamQuest should be created before implementation of the AdQuest further reinforced the committee's focus on instrument design. Further complications were created by the periods of delay that bracketed the contact with program staff.

Assumptions that were made in planning for the program contact phase

As it planned for contact with the program staff, the research committee defined the practitioners within the MHP as its primary target as it anticipated the need to secure staff acceptance of the risk project. However, although this purpose was articulated, the requisite steps in the process were not identified and planned. In fact, planning for contact soon became more client-focused than practitioner-focused. The committee believed that practitioners would embrace the risk project if they demonstrated that it was beneficial to practice - that is, that it led to discoveries - and did not interfere with the therapeutic relationship. The committee also used the program contact phase to address its own lingering concerns about the impact of the risk project on clients, rather than on any concerns that other staff might have.

In part, the change of focus - from practitioners to clients - that occurred as the work of this phase was defined reflects the committee's longstanding concern about the impact of research methods on clients. It also is indicative of the fact that its style remained highly organic and evolutionary rather than highly rational and planned. There was an evolving contradiction between the explicit definition of the contact phase - "focus on practitioners as they are the target beneficiaries" - and the implicit definition - "focus on the clients and staff will follow."

Another characteristic of planning was that the purpose of the "contact phase" was defined as preparing for implementation. The need to enlist the interest and motivation of staff soon took second place to thinking through the implementation steps. Planning for the contact phase was driven by the choice of an implementation date rather than consideration of what should be accomplished during the phase. This was partly a result of committee members dissatisfaction with the prolonged delays that had been encountered. Consequently the specific steps that would be needed to engage practitioners were never fully considered as committee members were looking beyond the phase to implementation.

The Research Committee's Assumptions About its Own Role and Approach

Another characteristic of the phase was the emergence, at its end, of conflicts within the research committee. Although the underlying reasons for this are discussed fully in the next chapter, a key contributor may have been the contradiction between the canonical definition of the phase and the actual work undertaken.

In Chapter VI, I described how the research committee's definition of its working model - non-expert research mentorship of non-committee members - conflicted with the actual model that it developed - that of advocacy. The committee did not consider its role in the contact phase to be one of developing staff training to help integrate the AdQuest into clinical practices. Instead, its "advocacy" approach emphasized a need for practitioners on the committee to demonstrate to their colleagues that the AdQuest would be beneficial to clients and not detrimental to them.

As a result, the planning phase implicitly focused on reassuring clinical staff by "testing" the AdQuest - and refining it as an instrument - rather than preparing for its "use" in practice. This approach produced some benefits. To demonstrate that it could be beneficial to clients and clinical processes the AdQuest was tested with long-term clients, a process that resulted in clinical discoveries that did inspire committee members and would be important in gaining staff support. The piloting process and the focus group process were chosen to establish the legitimacy of the AdQuest, and to enable committee members to "testify" as to their own experiences. These processes produced positive results in that they honed the AdQuest, showed a need for the FamQuest, and motivated committee members. However the process fell short of Savaya and Spiro's (1995) recommendation that training approaches be used to create an exchange with practitioners affected by the introduction of monitoring instruments. As a result, practitioners outside the research committee were not given much opportunity to raise questions related to the use of the AdQuest.

Research Committee Functioning and Intra-Committee Relationships

The tensions that emerged in the research committee, toward the end of the contact phase, show that the roles of committee members in shaping the risk project had not been clearly planned or defined at the onset. Neither had the impact of the project on the committee been anticipated. The risk project was taking a considerable amount of committee time. This provided some benefit as it helped give a focus to the committee, which was struggling with slow-moving projects and with a model for creating wider participation that was being severely tested. However, the long time-frames for design and implementation were taking an additional toll on the committee. Some within the committee viewed the risk project as draining previously available resources and into and administrative effort. As the committee began to consider the implementation phase, it was not well placed to do so. It was concerned about internal conflicts and was refocusing on bringing long-term committee projects to completion.

Organizational Culture and Practice Technology: Concern About Research, or Concern About Clinical Innovation?

The research committee did not develop its informal approach in a vacuum, and in some ways may have accurately judged the organizational culture during the contact phase. It chose to remain informal and to inspire and teach by example - to demonstrate that the AdQuest could enhance clinical work. These choices reflected a view that practitioners held firmly to the principle of professional autonomy and that a gradual implementation process would be the best way to influence their practice. Though a more formal training model might have been adopted as an approach, this may not have been more successful in recruiting staff interest.

Unexpressed and Underlying Concerns About Research

When the research committee first presented the risk project to staff in March 1998, its own definition of the project had evolved from the June 1996 "mental health database" to the March 1998 view of the AdQuest as a clinical practice tool. This presentation emphasized the research and programmatic aspects of the risk project and its intended benefits were iterated in terms of administrative and research practices. Little emphasis was given to its intended use as tool to enhance the assessment interview. In hindsight, this appears to be a serious error in but it was not noted at the time either by me or other committee members.

Why did this occur, and what was its meaning? The committee had more contemporaneous goal statements that it could have drawn on. Reflecting on this "naming and framing" process now, there are a number of explanatory theories that might be offered, all of which might have contributed. It might have been the result of poor planning for the program contact phase and a failure of the committee to define the phase as one in which program staff needed to be fully informed about the project and engaged in discussions about the practice implications of the AdQuest. It might also have reflected the continued ambivalence within the research committee about the true nature of the risk project: Was it clinical innovation or research? Another explanation might be that it reflected a hesitation among committee members to define the project as a clinical innovation, precisely because *the MHP's organizational culture was not one in which innovation was easily achieved.* In addition, it might have been evidence that the committee sought to establish its *legitimacy as a research group.*

The theory that it reflected continued concerns about the project's true nature and fear of research is supported by the fact that during each of the two staff sessions - March and April 1998 - little emphasis was placed on issues of integration into clinical processes and the overarching concern was the impact on clients, a recurrent theme in the history of the project. Practitioners were told that it would provide data for their use and that this would allow them to pursue their own research interests. Yet, it is not clear that pursuing research was of great interest to many practitioners outside the committee. Although the April 1998 presentation went further in exploring the concrete practice implications of using the AdQuest - and included a redefinition of the goals - little emphasis was given to how this might be done. The focus remained on broader issues such as confidentiality and consent - with the later derived from concerns about client consent to research involvement.

However, shortly afterwards, during the implementation phase the limitations on the committee's ability to influence MHP practices overall, because of the lack of a formal relationship between it and other program development and supervisory efforts, became clear to me. In the light of this awareness, I believe that the focus on the programmatic and research potentials of the information that the risk project would generate, reflected the committee's innate, intuitive and unspoken recognition of the difficulties of clinical innovation. The committee did not yet confront the issue of clinician autonomy perhaps because of the limits of its formal authority, its informal linkages to the practice, and the fact that some of its members may have shared that value of practitioner autonomy.

The Effectiveness of the Research Committee in Creating a Vehicle for Reflection During the Program Contact Phase

Driving the formation of the research group, and the risk project, was the explicit assumption about its value as a vehicle for bridging direct practice, management and research. As such, a key aspect of its purpose related to its ability to encourage learning and help create mechanisms by which practice-concerns could to be openly discussed. I am reminded of Grasso and Epstein's (1987) statement, discussed in Chapter IX, that "[F]or persons to learn they must be free to doubt" (p. 91) so as to be able to expose their practice problems comfortably. During the program contact phase the challenge to the committee was how to maintain these processes within the group and to extend them beyond it to other practitioners. Grasso and Epstein suggest, as do Savaya and Spiro (1997), that staff training is an essential component of this process, but it is not clear that the research committee was sufficiently formal and integrated into the MHP practice to take on this role.

The research group did encourage reflective processes among its own membership, both when functioning smoothly and when conflicts emerged. Its informal relationship to other program activities may have limited its ability to create vehicles that would allow practitioners to express doubt about their own practice problems. The process used to introduce the AdQuest to the MHP overall did not lead to acknowledgment by practitioners that there might be any difficulty experienced in incorporating the risk project into practice. Questions that did arise in the staff meetings focused on issues relating to clients - confidentiality, consent, and so on. While this was a necessary aspect of helping staff work through any issues that they might have with the project, no one raised his or her own practice problems or any questions that might be perceived as reflecting a lack of ability.

As I described in Chapter IV, Savaya and Spiro (1997) describe their own effort to introduce a clinical monitoring tool into a practice as a failure because it was not embraced by practitioners despite their taking an approach that used training and staff feedback to modify their instrument. They report that, as a result of practitioners not using the instrument, its use was mandated. This led only to superficial compliance and eventually the project was dropped.

Given the MHP's organizational culture, and the group's relationship to the overall program, it is unclear that development of a training module would have been an effective strategy. However, the committee did not consider alternative methods to create opportunities for MHP practitioners to experience similar learning processes from which its own members had benefitted. Doing this might well have furthered the original aims of the contact phase and created valuable exchanges that reflected practitioners' viewpoints about using the AdQuest and FamQuest.

Conclusion, Naming and Framing the Problem of Program Contact: The Research Committee's Relationship to the MHP and the Organizational Culture

What do the assumptions that I have described say about how the committee "named and framed" the program contact phase? First, I will remind the reader that Schon (1983) defines naming and framing as a process in which amorphous and highly complex problems are shaped into workable problems. Schon warns that the reflective practitioner can, at times, be drawn into a fundamental error - a result of his "isolation" - in which his theories-in-action blind him to certain phenomena. In the contact phase the committee framed the problem as one of the need to reassure practitioners about the AdQuest by using it themselves with their own clients, in this way they chose to try to demonstrate its clinical effectiveness rather than engage with practitioners and identify and discuss their concerns about its practice implications. Was this fundamental error or an accurate, intuitively correct reading of the organizational culture?

The approach taken was to have practitioners on the research committee work with the AdQuest so that those "outside" would follow. This reflected a long term committee pattern and attempt to generate interest in research among program staff. The committee assumed that it was well integrated with MHP program activities and that staff would follow its lead. How well integrated was the research committee with the MHP? Committee work was episodic and projects advanced in bursts of activity, mirroring the episodic nature of annual service utilization patterns and overall work flow within the MHP. Reports given in MHP staff meetings were not a very effective method for keeping staff truly informed of the committee's work. Nor would they build interest. Often, there was little to report and reports were a poor way to demonstrate the benefits of research involvement to MHP practitioners, who did not participate in committee activities. Some staff, hired after the committee became engaged in ongoing projects and less involved in trying to foster wider interest, might have been uninformed about its activities. Even for those who were more aware of its work and approach, the committee's determination to keep practice principles front and center would likely seem abstract or unclear.

Informality and voluntarism, the watchwords that formed the foundation of the research committee approach and modus operandi, continued during the contact phase. Committee members engaged in informal efforts to keep staff informed and the AdQuest had been widely and frequently circulated, throughout its development, among practitioners, senior staff, team leaders and managers. It had been discussed in operational management. The work of the research committee was not formally linked to the MHP operational management effort, or to team functioning, or other program development efforts. Furthermore, the nature of this relationship had not been considered by the committee. It remained committed to informality and many members may have assumed that my presence and that of the social work supervisor assured its integration into operational management efforts.

Overall, it seems fair to conclude that committee relationships with overall program activities were not as strong as members might have thought and that informality prevented the committee from extending its activities to create appropriate learning opportunities for other program staff. At the same time, there are suggestions that committee members chose to emphasize the research paradigm - despite their concern about it - as a way of establishing their own legitimacy. The informal feedback, from some practitioners who were not involved in the committee, that perhaps the MHP values were changing and that research was valued over practice, may have also been a reaction to this. The presence of these tensions also suggests a feeling of an "in-group" and an "out-group." This adds support to the theory that the committee had become focused on internal processes rather than on maintaining relationships to the overall practice. As members gained confidence in their competence with PBR, they may have enjoyed the sense of membership in a unique and special group.

Despite the obvious weakness in the committee's approach - specifically its not engaging practitioners in a discussion of how the AdQuest might directly affect practice - the approach might, in other ways, have been appropriate to the MHP culture. The committee initially did not define the project as a clinical innovation but as research, despite the ambivalence about research that was sometimes evident in the committee's approach. In some ways, the remote, abstract, metaphor of research - seen in the definition of the risk project as a "database" and in the concerns about "clean data" - might be less immediately threatening to practice than the concept of clinical innovation. Innovation would, by implication, mean that common practices would be changed.

In its second meeting with staff, the committee changed course to focus on the clinical sues of the AdQuest, but did not discuss the question as to how it might affect practitioners. Nor did they elicit discussion of this issue. They were excited by their own discoveries and assumed that others would be too. One reason for this change may have been that, in the month that passed between the two staff meetings, committee practitioners had an opportunity to process their experience and to discuss the clinical value of the AdQuest. Perhaps they were also feeling new competencies and a new sense of efficacy as they explored the application of PBR directly in clinical practice, a goal that none of the committee's other projects had attempted.

In conclusion, the framing of the situation during the program contact phase, as one in which practitioners on the committee must lead and inspire their colleagues, may have been the committee's first true attempt at mentoring. Despite the committee having initially framed the project for staff as "research-based," the ground upon which they chose to "lead the charge" was not the unfamiliar ground or research. Research committee practitioners chose the home ground, the familiar turf of practice and described their use of the AdQuest clinically. That they seemed ambivalent about the research versus clinical nature of the project suggests that they intuitively knew that the

MHP culture was more threatened by clinical innovation than by research. Given the committee's unclear role definition and informality in relation to the MHP, their approach had strengths as well as weaknesses.

Chapter IX. The Program Implementation Phase

1. An Overview of the Chapter

The program implementation phase can be separated into two discrete stages. Stage one involved the limited implementation of the AdQuest and FamQuest with only one of the three MHP interdisciplinary assessment and treatment planning teams. It occurred between the end of November 1998 through February 1999 and was followed by a two-month period of instrument modification and planning for the next step in implementation.

Section two of this chapter describes how the planning for this was loose, hurried, and fragmented due to divisions within the research committee about the risk project's effect on its resources and time. As a result the committee decided to delay full-scale implementation and conduct a limited pilot with the five practitioners in one assessment team. Though these practitioners were asked to explore how to use the instruments in the assessment process they were given considerable latitude as to how to do this.

Section three describes this initial implementation experience, which was a partial success. The AdQuest and FamQuest were able to generate clinical information but practitioners were wary of discussing the AdQuest with clients, and rarely did so in the first intake session. When it was discussed, these discussions were used to address anomalies between the client and practitioner's views in the most problematic cases.

The experience with the pilot process led to some modifications in the instruments and led the committee to begin planning for stage two in which they would be introduced to all three MHP assessment teams. Committee members were encouraged by the clinical information that the instruments were generating but were divided about whether their use during the first intake session should be mandated.

Section four describes how in planning for the second stage of implementation with all three MHP teams, committee members saw that a more formal approach to implementation, though desirable, was not yet practical. This was due to limitations imposed by the committee's informality and the fact that its work was not coordinated with that of other MHP activities. This lack of coordination resulted from there being no definition of the committee's relationship to teams, supervision and program development. Implementation was thus continued in a relatively loose, exploratory manner. The second stage began in May and by July 1999 implementation was occurring in all three teams. During this stage a period of intensified planning was initiated as the research committee began to come to grips with the problems of implementing the AdQuest and FamQuest as clinical tools.

This case study ends with the prescriptive planning process that occurred after implementation was piloted, which was one outcome of the risk project. Section five describes how the committee recognized that its past modus operandi - informalism and incrementalism - had limited its effectiveness. In turn, this recognition led members to reevaluate the committee.

Recommendations that emerged included the call for a more formal committee structure, a more formal definition of its function, and a more formal contract with members regarding research participation. In order to formalize the committee structure, I decided to step down as committee co-leader. Reevaluation of how the risk project could be implemented more effectively led to a reconceptualization of it as the first step in a clinical information system that the committee would undertake to develop. A revision of the research committee's mission, goals, structure, and relationship to other MHP subsystems also resulted. Section six outlines the recommendations that resulted including the development of a research agenda integrated with staff in-service training, program development and management systems. The timelines for these events are illustrated in Figure 8 (see page 221).

Section seven ends the chapter with an analysis of the implementation phase. Implementation led to a reflective process in which many of the implicit assumptions that had guided the committee's approach over the four previous years were made explicit and reevaluated. In considering how to implement the risk project fully, the committee framed the implementation situation as one which should allow practitioners the leeway to explore the practical implications of the instruments and to experiment with their use in practice. This reflected, not only the acknowledgment by the committee's of its limitations at that time but also, the perspective that this exploratory, low-key approach would in itself create the necessary dialogue about the implications for practice. The committee's view was that this dialogue should be encouraged but via a low-profile approach within teams and in supervision.

Figure 8: Timelines for the Implementation Phase

November 1998 to June 1999

☐ 1999

◊ October 1998, The research committee reevaluates using a focus group methodology

◊ October - November 1998, planning for implementation: a decision to implement in a "pilot" with only one team

◊ November 1998, "stage one" implementation of the AdQuest & FamQuest begins with one team of 5 practitioners

◊ February 1999 - "stage one" complete, 50 adolescents complete the AdQuest

◊ March 1999 - the instruments are modified

◊ A change in research committee leadership

◊ April 1999, planning for "stage two" - full implemntation with 3 teams

- O The committee considers and rejects using an "administrative mandate" that the AdQuest be reviewed with clients in the first interview
- O The committee considers "training" practitioners for the risk project, but decides against this
- O The committee recognizes the limits of its approach & structure, sees the benefits of a more formal role in the program development & administration

◊ May 1999, *Stage two implementation is planned* as a "loose," explorative process

◊ June 1999, Implementation of the AdQuest & FamQuest begins in all 3 teams

This case study ends

Epilogue

◊ July - December 1999, the committee initiates a planning process

- O The committee develops a more formal role
- O The *committee structure becomes* project- focused
- O A Clinical Information System is planned

2. Planning for Implementation: Fall 1998

In their description of Differential Program Evaluation Tripodi et al. (1979) describe the program implementation phase as follows:

> In this . . . stage the program fully engages its clientele and gives service/or applies a change technology. The success of the program implementation stage rests in part on the attainment of the necessary conditions of program initiation and contact. It also depends on the relevance of the service offered or on the efficacy of the technology employed. The program implementation stage overlaps with and is a result of effective program contacts.
>
> The purpose of program-implementation is synonymous with the ultimate goals of the program. It is here that the outcome of program planning can be measured (p. 33).

In contrast to this rational scenario, preparation for implementation of the risk project was loose and hurried. During the fall of 1998, having seen the July target date slip by, research committee members reached a consensus that the project must be moved forward. Little additional preparation of practitioners was now done although five months had passed since staff meetings had been devoted to the project. Among the factors that contributed to this sense of urgency were committee members' concerns about delaying further as it was thought that this might erode the project's viability. Another primary factor was that the committee co-chairs were preoccupied with addressing intra-committee conflicts that had recently emerged. The lack of a well-defined risk project team that could plan implementation became a further obstacle as the committee became focused more on committee processes and less on projects. I will address each of these in turn.

In Chapter VIII I described how, as the contact phase ended, the committee became preoccupied with issues that arose after my co-chair and I voiced our concerns about its overall effectiveness. Many members came to believe that further delays would weaken implementation and lead to a decline in interest among practitioners outside the committee. My co-chair and I thought that moving the risk project forward might motivate other committee members to complete slow-moving projects more quickly. The committee decided that implementation would create an exchange with other MHP practitioners about use of the instruments in practice. It viewed this exchange as a condition of the implementation phase not of the program contact phase.

As the committee planned for implementation it simultaneously began to address intra committee tensions, disputes and divisions that had been evident at its meetings. One result of the decision to confront these issues was that during the fall of 1998 the committee was more divided and, therefore more focused on its own process than on the project work. These conditions paradoxically heightened its determination to implement the risk project and simultaneously hindered its ability to plan. Divisions had arisen between members as to whether the risk project was diverting effort and resources away from other projects or, in contrast, providing opportunities for the committee to coalesce and be more effective. This difference, among others led to a reluctance to devote committee time to the risk project until this concern and others were addressed.

In 1996, the risk project had been conceived of as a whole committee effort but, by the fall of 1998, this was an unwieldy vehicle for planning the project's implementation because the committee was preoccupied and fragmented. With no identifiable "implementation" group, committee leaders were, in effect, leading the effort to plan and implement the risk project. One committee member who had provided informal leadership to the project in the initiation phase took on new program responsibilities and eventually left the committee. Without a designated project group, decisions about the project were often made informally in the course of other activities. As a result, the criticism expressed by one committee member that the risk project had become administration's project, was becoming a reality.

In the spring of 1998 the committee's intention had been to implement the project in all three of the assessment teams on the three mornings weekly when intakes were conducted. But due to lack of adequate space, this was not possible. The original plan, to have clients complete the AdQuest within practitioners' offices was considered impractical as it would delay practitioners during busy intake mornings and lead to practitioner resentment and resistence. The committee decided to start a pilot with one team that met on a day when space was available and anticipated that more than 50 new clients would complete the AdQuest by the end of February 1999. In turn, this "pilot" could be examined, data entered and studied, the instruments refined, and the implications for broader implementation understood.

This decision was not made simply because of the committee's preference for small-scale, incremental approaches, but for other situational reasons. There was a sensitivity about the allocation and use of resources as this had become a contentious issue for some in the research committee. Entering data for a smaller number of clients would be less costly and more efficient in the long run, than if implementation were begun with all three teams. The pilot would almost certainly result in the identification of weaknesses in the instruments that would require modifications to the instruments and the database.

Starting with one team would simplify communications about the implementation experience. Overall, it would require less effort initially and allow some trial and error. Stage one was framed as an experiment from which knowledge would be gained that would increase the chances of success when the project was fully implemented. The committee leaders thought that the second stage - implementation for all teams - could be started in the spring of 1999. In late November 1998, the AdQuest was formally initiated in the intake practice by a team of five clinicians.

Planning for Stage One - Implementation with One Team: November 1998

Planning for stage one occurred over a brief month-long period and focused on dealing with details - changes in client scheduling, clerical staff coverage, and the flow of paperwork - and the creation of protocols for nonclinical staff. These protocols outlined how staff should discuss the intake process over the phone, detailed the procedure to follow when clients and families first arrived, addressed the identification and handling of clients with reading or comprehension problems, anticipated questions that parents might have, and addressed issues of confidentiality.

The committee members thought that practitioners on the team remained open to the project. The plan was that practitioners would be reoriented to the project in team meetings by their team leader, a social work practitioner who was a research committee member. This approach was initially suggested by the team leader who thought that it would increase a sense of ownership of the pilot by the team. The committee wanted to avoid being seen as imposing new practice methods so the possibility of restructuring the initial interview for the pilot process was not considered. The expectation was that an organic process would evolve in which a methodology for integrating the instruments into practice would manifest itself as the practitioners gained exposure to the AdQuest.

My own "hands-off" approach was partly influenced by this dissertation study. In contrast to other initiatives that were on the formal management agenda for development, I viewed the implementation process as an experiment and assumed that the practitioners on the team would have a degree of "natural" interest. My approach was not to try to shape the practitioners' responses and this was congruent with the approach of the committee as a whole. With tensions emerging regarding dissertation studies, as I described in the last chapter, I was hesitant about how my own efforts might be perceived. This influenced my decision to support a very loose implementation process.

Other factors contributed to the committee's "hands-off" approach. First, committee members, as a group, wanted to avoid the appearance that research was being imposed on practitioners. This viewpoint had shaped the committee's preference for an incremental, opportunistic and informal approach to developing practitioner research from its inception in 1995, as I have described in Chapter VI. Second, practitioners were assumed to have a high level of interest and curiosity because, as a group, they were seen as highly motivated to learn. During the initiation phase the risk project had been viewed by committee members as shaped by shared management and practice agendas and this view shaped the assumption that other practitioners would embrace the risk project just as practitioners on the committee had.

The committee might have overestimated the strength of its relationship to the practice overall. The issues and strains that were newly emerging within the committee, over whether the project was clinically or administratively driven, had yet not been fully explored and were not fully understood. Although the committee had not evaluated how well it was integrated with other MHP activities, members were becoming aware that a more formal, "hands on" approach to implementation - in which protocols for the AdQuest use in assessment were developed - might require a "tighter" approach by the committee. However, only in January 1999, did it become clear that the committee was less integrated into other MHP program activities than it had been previously. Only in March 1999 did committee members become aware that other MHP practitioners might be less aware of the risk project than was desirable.

3. Implementation Stage One: November 1998 - January 1999

Early in November, less than a month before implementation, the pilot team was informed of the plan to have them implement the AdQuest and FamQuest. The instruments were recirculated to team members and discussed. Practitioners were told that they were expected to review the completed AdQuest with each client during the first intake interview and the team leader reported to the committee that the team seemed open and at ease with the plan.

Stage one began late in November 1998 and ended in mid-January 1999, during which time 50 AdQuests and 25 FamQuests were completed. Monitoring focused on the reactions of clients and their families to the instruments, on the experience of the support staff, and on sorting out small-scale logistical problems. To everyone's amusement some clients appeared to be walking away with the clipboards used to hold the AdQuest so that after two weeks none were left. Questions and comments that clients or parents raised were monitored and support staff were debriefed weekly after each intake morning.

Twice, when an adolescent and parent were placed in separate rooms to complete their questionnaires, parents expressed the concern that the fact that they were being separated from their children was motivated by the MHP wanting to leave them open to criticism from their children. They seemed to fear being blamed for their adolescent's problems. On two other occasions, parents expressed concerns about the possibility that MHP staff would recommend child welfare agency involvement, and revealed that they had a history of such involvement. That these issues were raised was not considered unusual by practitioners, because parents frequently had questions about the MHP practice of interviewing adolescents alone as well as with their parents. This practice was explained to families and their concerns were addressed during the assessment interview by a practitioner. The fear that client confidentiality might be compromised, if a parent asked to see the completed AdQuest, proved to be unfounded. In contrast, some parents were concerned that their own responses should not be revealed to their adolescent child.

A review of the first twenty completed AdQuests and first ten completed FamQuests suggested that adolescents and parents were filling out the questionnaires completely. From the range of responses, in individual questionnaires, to the Likert scale items, it did not appear that respondents were simply hurrying through and selecting non-controversial, more socially acceptable answers.

Practitioners, meanwhile, were not being monitored. Debriefing was conducted by the team leader in team meetings. After three weeks it appeared that practitioners were rarely seeing completed questionnaires before the first interview so a review with clients was not happening. They did not volunteer this information until asked directly about their reviewing practices.

Practitioners' Use of the AdQuest During Stage One

Exploration of how practitioners adapted to the AdQuest was done in the team, by the team leader, shortly after completion of the pilot. It was repeated in April 1999, when more specific information was sought after, because the research committee decided it had inadequate information with which to evaluate the experience. I also followed up informally through individual discussions with most practitioners. The following picture emerged.

Practitioners did not routinely review the AdQuest with clients during the first interview. They generally scanned the completed AdQuest before the interview and put it aside, only reading it carefully after the interview was completed and the client was gone. Discussion of the AdQuest in the first interview seemed to occur in less than a fifth of the cases. When it did occur, it seemed to be prompted by one of two circumstances. In some instances dramatic differences between the information gathered by interview and questionnaire caught the practitioner's attention. At other times, practitioners thought information being given on the AdQuest was uncommon and worthy of discussion. For instance, a client's indication that he wanted help with a substance abuse problem, an uncommon request, prompted a review by the practitioner. Discussion also occurred when a particular problem was evident to the practitioner but the client was hesitant to discuss it.

Estimating the number of clients with whom the AdQuest was not discussed is difficult, though this may have often been the case. It appears that practitioners most frequently discussed the AdQuest with clients in the third, and last, assessment interview. Clients who reported higher risk behavior appeared most likely to prompt a discussion. In these instances, practitioners seemed to look for comparisons between information derived from an interview data and that derived from the questionnaires.

Each practitioner varied in his or her utilization of the AdQuest. Decisions regarding its use seemed situational, based upon the unique nature of the case presented by each new client. Individual practitioners did not appear to settle into a routine pattern of use with all clients. Only one practitioner appeared to have largely ignored the AdQuest, reporting that it was not particularly relevant to the assessment process.

Practitioners appeared to have used the information generated by the AdQuest to supplement the information gained from interviews to help them complete the psychosocial assessment forms at the end of the assessment process. Information from the AdQuest was sometimes, but not routinely, used in the presentation of cases to the treatment planning team following completion of the assessment. In very few instances was information from the FamQuest and AdQuest brought into case discussions in supervision, when practitioners were facing particularly difficult “family” cases.

Overall, the instruments remained peripheral to existing assessment practices unless there were specific issues and questions raised during the assessment review if particularly difficult problems were encountered in developing a clear conceptualization of the client's problem. It appeared that the practitioners were most likely to use the information generated by the questionnaires when faced with puzzling situations or when asked directly about that information in the team. Practitioners seemed generally interested in the information generated by the instruments but not in allowing the instruments to change their practice rhythm and style of interviewing.

More generally, practitioners reported that implementation interfered with their work. Many clients were not completing the AdQuests in time for the scheduled interview, taking almost twice the fifteen minutes allocated. Practitioners and the team leader reported that there was inadequate time to complete the work of the first interview. Practitioners came to feel rushed and with less than forty-five minutes of the allotted hour remaining they felt that it was even more difficult for them to review the AdQuest.

One team member openly questioned the usefulness of the AdQuest saying that competent practitioners should cover the same ground using the MHP's current, interpersonal assessment method. However, all felt that it had added to their work by delaying them. Most thought that the information generated by the AdQuest and FamQuest helped them understand their clients better. However, they did not think it was it as important to discuss this information directly with clients unless they saw a pressing reason to do so.

Grasso and Epstein (1987) and others (Savaya and Spiro, 1997) suggest that monitoring will only succeed if is rewarded and integrated with the work of organizational subsystems. However, the highly informal implementation process used in stage one resulted in no procedure being developed for integrating the instruments into the team process. The team leader and psychiatrist only referred to the questionnaires when hearing case assessments that were unusually complex or seemingly incomplete.

From discussions with individual team members, I later learned that gradual changes had been introduced into the team process due to other efforts the psychiatrists had initiated. During the summer and fall of 1998, they had been focusing on the Global Assessment of Functioning (GAF) scale (American Psychiatric Association, 1994). The GAF, though not new to the practice, but it had received no emphasis in the past. Increased use was also being made of Child Behavior Checklist (CBCL) (Achenbach, 1991), a clinical RAI that had been little used previously within the MHP. This emphasis on the GAF and CBCL greatly influenced practitioners' prioritization of the tasks that they needed to complete at intake. This was mixed news. While it was "bad news" in that it had meant that the risk project had been given third place on practitioners' list of priorities, it was a positive sign that with the proper direction from team leaders and psychiatrists practitioners would integrate the information generated by the instruments into their formulation and presentation of cases.

Sidell et al. (1995) suggest that the "practitioner viewpoint" of task orientation, that involves an "atomistic" view of practice in which problems are approached in small, incremental steps, can be a barrier to practitioners' acceptance of research methodology. In health care settings this is often reinforced by practitioners' perceptions that their work is highly pressured and that they lack time (Adler et al, 1993; Marsh, 1983; Pruett et al, 1991; Williams & Hoppes, 1988). For MHP practitioners a similar task orientation and utilitarian approach to the assessment process and to the team review seems to have been strongly present. One suggested to me that, while most practitioners might not attach any inherent value to the GAF scale or CBCL, focusing on these scales had practical value as it enabled cases to be moved through the review process more easily and it resulted in faster access to psychiatric evaluations for their clients. In contrast, I was told, the risk project had yet to show such instrumental value and, in fact, it was perceived as a hindrance.

The team leader's viewpoint was also an instrumental, utilitarian one. Efficiency on intake mornings was a priority and reviewing the AdQuest interfered with this. The team leader explained that practitioners "must work hard and fast to get their work done," as it meant focusing on obtaining a problem statement, engaging the client, and assessing any imminent risks. Similarly, she said the team had an enormous workload to complete in its meetings. This might be made more difficult if members routinely discussed the AdQuest. She also expressed optimism that the information generated by the instruments could potentially help the team functioning but she was unsure how this could be done. As it stood, the AdQuest appeared to be interfering with the routine work.

There was little direct response to the FamQuest. As there was no expectation that it should be reviewed in session, it appeared that practitioners viewed it as tangential to usual assessment processes. Only in cases where difficult family interactions were complicating the assessment did practitioners turn to it. This may reflect the fact that practitioners were less skilled in family therapy than other approaches and tended to be adolescent-focused. They may have been unsure as to how to integrate the information generated by the FamQuest into their practice. The group that had designed the AdQuest initially interpreted this phenomenon to mean that the FamQuest was flawed, was misunderstood by parents, and that it was not generating useful information. Discussions of these perceptions in the committee and a careful review of completed FamQuests suggested that this was not the case and that the FamQuest was being approached by respondents with the same consideration and honesty as the AdQuest.

Modification of the Instruments

Between March and April 1999 minor modifications in the AdQuest and FamQuest were made. This was done to clear up problems that emerged when data analysis was done. It was unclear how many adolescents were actually in school as a question regarding this had been omitted from the AdQuest used in the pilot. Some questions considered superfluous or unrewarding were deleted or modified to shorten the time taken in completing the AdQuest. One example was the collapsing of a series of questions about "hard" drug use into a single question. The family life-events scale on the FamQuest was modified as there was concern that it might have confused some respondents. Some questions on the FamQuest were reworded to make them consistent with the AdQuest. Health educators, who joined the research committee in March 1999, suggested that the AdQuest be given a more appealing, less technical look. In turn, it was renamed "All About You" and the statements introducing each section were reworded to be less technical and more personal in nature. The finished AdQuest is attached as Appendix C.

4. The Research Committee Response to the Implementation Pilot: Spring 1999

Considerable discussion was generated within the research committee by the experience of the stage one pilot implementation process. This had a significant influence on the committee's reevaluation process that was then underway. Before I describe the risk project's impact on the committee, which I do in the next section, I will focus on the lessons that were drawn from the experience at that time and the effect they had on planning stage two of implementation. Though I describe them separately, these two processes cooccurred and were highly interrelated.

Planning for Stage Two - April 1999 to June 1999

Committee members were encouraged by the clinical information generated by the project but remained concerned about the relative lack of integration of the instruments into the direct practice. A debate followed concerning whether an administrative mandate should be used in the next stage, and many practitioners felt it should. I, and some administrative / senior staff did not agree. The committee's consultants broke this impasse by suggesting that some type of training process was necessary. They suggested that much more should now be done to create an exchange with practitioners about the instruments and current agency practices. Though it was difficult for the committee to envision developing a training effort was difficult for the committee - as this required a level of formality that was out of step with the committee process - the discussion helped reframe the problem and the next steps considered. Better integration of the committee's work with that of the teams and the overall MHP would be required if it were to continue.

It was clear to committee members that selecting a methodology for integrating the instruments into the intake practice, developing protocols that helped practitioners use the instruments effectively, and creating a program-wide practitioner training, would depend on a more formal role being defined for the committee. In addition, better integration of the committee's work with that of the MHP operational management group and with the teams, would be required if it were to complete these steps. This would take time and a concerted effort. Members agreed that the AdQuest implementation should continue even while the broader issues were addressed. They set about deciding what more immediate steps could be done to continue to move the risk project into the practice - even though this would result in a far from perfect implementation plan. They identified some heuristics to guide this process.

First, the committee decided to use the team structure, and differences in team cultures and styles, to experiment further. In contrast to large staff meetings, team meetings were considered be the most "natural" places for exchange to take place - if time were carved out for it. Second, for the present, implementation would remain a relatively "loose" process to encourage learning by allowing practitioners to discuss practice problems openly. Third, a limited mandate would be used - each team separately must decide exactly how, and when, individual practitioners would discuss the completed AdQuest with clients. Individual practitioners could not opt out of doing so.

Though the risk project was not defined as an effectiveness measure it might be experienced as such by a practitioner because it provided baseline information with which the assessment interview or treatment plan might be compared. Grasso and Epstein (1987) suggest that when introducing effectiveness measures every attempt must be made to avoid an atmosphere in which pressure to perform limits practitioner self-exposure. Weissman (1983) also suggests that lines must be drawn between the program evaluation and evaluation of individuals. Though this did not seem to have been a problem during the implementation pilot, the decision to ensure that stage two remained loose and was shaped by team decisions was in keeping with these principles.

The committee understood that practitioners who had conducted the pilot had not directly expressed feeling monitored. They had focused on the fact that the AdQuest slowed them down both during the first session and in the team. Yet, the committee decided that practitioners might have underlying concerns about monitoring and self-exposure. At the time it was unclear to me, as it remains today, whether this reflected the concerns of practitioners on the committee about the impact of research and evaluation methodology. Perhaps they were privy to information from colleagues regarding this issue and yet unwilling to tell me about it.

Fellow committee members held firm to the view that practitioners should become accustomed to the AdQuest without being held individually accountable for how well they worked with it. They felt that giving each team a measure of control over its choice of implementation process would help draw lines between the assessment of how better to implement the instruments and the evaluation of the individual practitioner's performance.

The committee recognized that preparatory work must be done with all three team leaders to enlist their support for the project. This highlighted the fact that research committee efforts needed more effective coordination with operational management meetings that included managers, team leaders and psychiatrists, and having better integration would help the project to become a priority to all. The experience gained from stage two would be utilized to identify a final implementation plan including the development of formal protocols for training staff.

I met individually with the three team leaders several times to build support for the project. I focused on clarifying its purpose, assessing their concerns, enlisting their ideas, and exploring factors that would need to be considered in approaching each team. I viewed this as essential because the research committee was largely occupied with the work of revising its own structure and planning completion of other projects, and the risk project lacked a defined project group to carry it forward.

The AdQuest was modified to identify the specific team to which the case was assigned to allow reports specifically for each team leader. Team leaders were invested in having information about each team's caseload, that is, aggregated information regarding risk factors for the team's clientele overall. The HIV program team leader believed that the HIV Program clients required more intensive services than others. Such information could help her with external relationships, such as negotiating with funders and, within the HIV Program team, help her develop rational and equitable productivity standards. A second team leader, who was responsible for MHP violence prevention and treatment services, felt that clinical information would help to identify clients and in program building.

The second team to implement the instruments was the HIV program team, which in June 1999 chose to review the AdQuest with clients in the first session as had been intended in its design. Practitioners on this team shared the team leader's interest in inventorying client risks to ensure that clients enrolled were eligible for services because funder mandates regarding client status were clear and rigid. This constraint, coupled with the program's focus on "higher risk" adolescents, meant team members had to be more aggressive in case-finding to maintain an adequate client base. The HIV program team was invested in defining client risk factors early in the intake, in contrast to other teams that conducted more problem-focused initial sessions. HIV practitioners were given more latitude in their first session, scheduling clients at ninety minute intervals as compared with sixty minutes for the other teams. As I described in Chapter VI, the HIV program's culture valued risk-focused interviewing and risk reduction counseling.

By the end of June the third team had formed a plan to review the AdQuest in the first session, changed this plan in the face of divisions, and finally agreed to disagree. They had decided that each practitioner would develop his or her own implementation methodology. This team was characterized by having the most and least experienced practitioners as the team included several trainees. These trainees, psychology externs, appeared to be comfortable reviewing the AdQuest in their first session. The team leader viewed this as a function of their training in the use of diagnostic and assessment tools and their not yet having developed practice habits.

Implicit in this view was the assumption that practitioners' preferences for informal and idiosyncratic assessment styles resulted from ideologically-driven practice theories and personal styles built on habits. As I discussed in the last two chapters, this interpretation of the great variation in individual practices had become quite widespread among committee members, ever since questions had arisen as to how confidentiality was handled. Only at the end of the study, as I describe in section five of Chapter X, did I come to view these varied and highly informal practices as serving a valuable engagement function. I came to see them as allowing practitioners the latitude to tolerate risky client behaviors without necessarily compromising the confidentiality of the treatment relationship.

Next Steps: Planning for the Implementation of the AdQuest and FamQuest with all Three MHP Teams

Plans for stage two of implementation had been shaped by the committee's awareness of the limitations of the approach used in stage one. However the committee considered and rejected the proposal, that some practitioner members made, that I mandate that practitioners review the AdQuest with clients during the initial interview. It planned to continue its "loose" approach to further implementation. Committee members were now aware that a more formal approach to implementation might be of benefit in developing more uniform use of the instruments by practitioners than had been the case in stage one. They discussed whether some form of training for MHP practitioners might be appropriate. However, they did not feel prepared to conduct training without first developing a better understanding of the issues that practitioners might encounter. Committee members had not yet agreed on how the AdQuest should be used. Though in the initiation phase they had been committed to having clients complete the AdQuest prior to the first interview, so that practitioners might review it as part of intake, they were now reluctant to prescribe how and when practitioners should review it with clients. Members felt that before they could develop some type of training for MHP practitioners they must first create opportunities for a less formal exchange with them. They decided to use the three teams as the preliminary forums for this. In continuing with this informal approach, committee members were aware that without clearer expectations within teams about how the AdQuest and FamQuest should be used, implementation would still be partial, highly exploratory and loose.

Several lessons that had bearing on the committee's decision about how best to continue with implementation were emerging from its self-evaluation. Committee members, aware that their options for implementation were limited by the committee's voluntaristic informality, defined three areas of the committee model that would need to be addressed. First, most members agreed that a more formal contract was needed regarding the expectations of research committee membership, though they may have differed on the details. Second, most members felt that a more formal definition of the research committee's functions in relationship to other MHP activities, and better coordination between them, would help the committee be more effective. This effort should be integrated with other program development efforts, and with the MHP's and staff in-service education. Furthermore, staff in-service education should be made more rigorous, should be linked to ongoing program development, and should be more focused on PBR overall. Third, within the committee there was a growing realization that the relationship between the committee's work and clinical practices should be more clearly defined and formalized.

Discussion of training practitioners to use the AdQuest led the committee to revisit the original definition of the risk project and to examine their views regarding the use of the risk project. As I described in Chapter VII, in 1996 the risk project had evolved from the broad concept of a "database" that would be used for research purposes as well as for program enhancement. By June 1999, committee members and for team leaders recognized that the risk project could generate relevant and useful clinical information but felt that they had not yet found ways of having this information influence practice decisions or program development. As the committee discussed the uses of the risk project and its clinical implication, the impersonal, non-clinical, research -based metaphor of "database" became replaced by the practice-friendly metaphor "clinical information." Discussions began within the committee and operational management meetings about the nature of clinical information systems (CIS) and how to create an organizational culture in which use of clinical information derived from PBR methods could become common and accepted practice.

The termination study, which was now nearing completion, and the risk project were viewed as building blocks that could be elements of a CIS. Viewing the risk project as the first step in the development of a CIS gave the committee a framework with which to think about its own programmatic and clinical role. It embraced the idea that the committee could be an important forum for planning a programmatic PBR agenda that would ensure the integration of the AdQuest, and other tools that generated clinical information, into practice. As I will now describe, the research committee began to reexamine its effectiveness, vision, structure and methodology. As it did so, the notion of a CIS began to take a firmer hold.

5. The Research Committee Reevaluates

During the Fall of 1998, as implementation began, the committee leaders began an active review of the committee structure and methodology. These discussions continued into the spring of 1999 when the lessons learned from stage one of implementation led the committee seriously to reexamine the assumptions that had been the foundation of its approach. In this section I describe the process - undertaken between November 1998 and March 1999 - by which the committee sought to clarify and address these issues, and what was then discovered. During this period I stepped down as committee co-chair and a senior practitioner took my place.

The reorganization of the committee was prompted by divisions arising within the committee after my co-leader and I raised concerns regarding the committee's effectiveness in October. In Chapter VIII I briefly described these divisions in the committee. They emerged fully during the implementation phase, so I will describe them in some detail and will explain what steps the committee took to address them.

Discussion of the slow pace of project work led to agreement among members that the committee needed to find ways to move more expeditiously. Members agreed that the committee was too involved "in process rather than with completing products," in the form of research findings, reports, presentations and papers. However, several very different, sometimes contentious, viewpoints were offered about why this was occurring.

Clarification of these viewpoints and their implications took place within committee meetings as well as outside them. This process of clarification involved formal meetings and informal contacts in which I sought to elicit as many viewpoints as I could about the committee process. Two committee meetings - one in November 1998 and a second in December 1998 - were devoted to the use of a focus group methodology to delineate the range of issues affecting the committee. In addition, I discussed these issues with individual committee members, and my co-leader and I met to develop an action plan to address them. Discussions also occurred in management meetings. Meetings in February and March 1999 were used by committee leaders to report to the committee, to plan, and to discuss the appointment of a new co-leader. I will now summarize the themes that emerged form these discussions and the conclusions reached by the committee.

Expertise and Resource Availability

Not all practitioners on the committee were active in research projects. Those who were - the great majority of committee members - stated that making progress was difficult because they felt isolated in their research work. They felt that they lacked the necessary skills to complete projects and that they had too few resources available to them. Questioning the adequacy of having a research consultant available to the committee only once a month, they stated that greater levels of assistance regarding project planning, creating or selecting instruments, creating databases, and conducting data-analysis, were required on an individual project basis. They viewed project delays as arising for "technical reasons," examples being lack of appropriate software and the need for training in the design of databases, data-entry and data-analysis. As one member put it, "It feels hard when you get so far on a project and then you're stopped . . . You get up a head of steam and then you have to wait . . . because you don't know what to do next." Overall, most practitioners in the committee appeared to feel comfortable with PBR concepts and in their application to defining "researchable" practice problems.

All the practitioners in the committee thought that it was not properly structured to support the specific tasks entailed in project work and that the level of consultation that they needed for their projects to progress was not available to them. They stated that their perceived lack of expertise left them feeling exposed when presenting at committee meetings. They described feeling "unprepared" for presenting their projects and felt that they required the availability of a consultant to help them prepare to use the research committee meetings well. They also felt that doing detailed project work at committee meetings was an inefficient use of committee time and that help in being better prepared for meetings would make meetings more productive for all. I concluded that the committee effort had not been adequately resourced, and agreed that it should be restructured to be more efficient and project focused.

The Risk Project and Resource Allocation

One practitioner, who had been instrumental in the early development of the risk project, but was no longer involved in project work, expressed the view that resources were awarded to "administrative projects" at the expense of clinician-driven projects. In this view, the risk project was being "driven by administration" with little practitioner involvement. My own view was that the risk project had drawn my own attention to the need for resources - support staff time and consultant time - for projects. This fact, paradoxically, reinforced the perception that the risk project was getting more resources than others - which in one way it was, if the level of committee time devoted to it was any measure.

Lack of Support for Social Work Practitioner Involvement in Research Within the Wider Organizational Context

Another concern, shared by the social work practitioners on the committee, was that the Medical Center "climate had changed" in a way that made it harder for them to engage in research activities. They stated that too little social work department support for research meant that social workers' PBR activities had become invisible. As one put it, research "is not considered important and central to our work . . . [as practitioners] . . . anymore." This state was compared with the more halcyon days of the nineteen-eighties, though few committee members had been on staff long enough to remember them.

Currently, practitioners felt there was a lack of Social Work Department support for training, lack of integration of research into departmental activities - concerning continuing education and practice - and lack of tangible rewards including financial rewards, promotion and academic appointments and other forms of formal recognition.

Although by this time the new AC Research Director was being recruited they did not view this development as concretely related to their own interests or efforts. The planned creation of an AC research unit was treated as a remote event aimed more at academic research development than practice enhancement. Furthermore they seemed to want to draw boundaries around the research committee, as "their own." This sense of ownership, the concerns about resources, and the desire to draw boundaries around the committee are all suggestive that it was becoming well established. As discuss in Chapter X, these were signs that the committee was approaching program stabilization, as Bielawski and Epstein (1984) define the concept, as it was seeking to be institutionalized despite its lack of a clearly defined formal role.

Although at the time I did not realize it, I also believe that the fact that resources, in the form of AC budget, were now being made available to begin creation of an AC research unit may have underscored the sense of some practitioners that they had been made to make do with too little.

Responsibilities of Research Committee Membership

Tensions emerged between members of the committee about the informal "contract" involved in committee membership, particularly between those practitioners who were involved in project work and the minority on the committee who were not. The former group urged that there should be clearer expectations and rewards for participation and that members who did not contribute to projects should not continue to participate.

Time, Rewards and Recognition for Research Work

Many direct practitioners felt that they should be given more formal recognition for their project work. Several expressed anxiety about what was expected of them, stating that expectations and rewards needed to be clearer. These members felt that those with projects should be granted formally structured "protected time," free from direct service activity, to move their projects forward.

This feeling was most strongly expressed by those who were not involved in dissertation work or in service coordination and supervision. They were particularly concerned about the lack of tangible rewards. As one put it, "those with dissertations may be more invested, they're getting something in the long haul." This group expressed feeling stimulated intellectually but as one put it: " I like coming and I'm learning but I don't think I can afford it. I'd like to continue but there's no time and I don't think I know enough to participate fully."

Practitioners who were involved in coordination of clinical programs were not totally sympathetic to these concerns and evident tensions existed between them and those whose work activity, apart from the committee work, was more purely "line work." Similarly, there were tensions between doctoral students and others. This division only appeared openly in committee meetings in the spring of 1999, but was discussed informally during the fall of 1998. Managers and practitioners with service coordination or team leader responsibilities were concerned about granting designated time to practitioners for research activities without the purpose of these activities being clearly iterated in terms of benefit the service from the research activity. They had several concerns, including the pressure to maintain productive services. AC practitioners were all on service budgets - as there was no funding budget for research activity - this created an accountability problem.

Practitioners who had the most administrative responsibilities were unsympathetic to formally defining "research project time" for another reason. They expressed the feeling that research work would always involve some use of "personal" time as it generated personal and professional rewards for practitioners. One feeling expressed by this group informally - but not in committee meetings - was that the "most professional" practitioners took on a broad range of programmatic responsibilities without negotiating formal allocations of time, and that they routinely worked longer and harder than colleagues with narrower role definitions.

They, and I, agreed that if practitioners were to be given time to conduct research they should be accountable for its progress. Those practitioners on the committee who were involved in supervision and service coordination shared this perspective with the managers. Research project work, in this view, should be formally tied to work expectations and performance appraisal processes overall. My own perspective was that formal recognition of practitioner research activity should be balanced with a clear and articulated relationship to the programmatic agenda. Rational decisions could then be made about what amount of practitioner activity could be afforded, and that this should clearly be tied to accountability and performance appraisal processes.

The Research Committee's Relationship to Other MHP Activities

The question as to how well the research committee was integrated into other MHP activities, was a constant presence in the planning for stage two of the risk program implementation. Several issues were highlighting this question.

First, practitioners in the research committee were asking for more formal recognition of their research activity. Second, it was becoming evident that resources needed to be more available for projects and that some criteria needed to be developed to determine resource allocation. Third, the make-up of the committee had been questioned by the practitioners who were most active in project work because they felt that some members were not contributing. They were seeking a re-formation of the committee and wanted it to reflect more diverse areas of the MHP. Fourth, reorganization within the AC had expanded the role of senior staff in the MHP who were now supervising health education and mentoring activities. Other health professionals, such as health educators, were interested in initiating research and evaluation projects and senior MHP staff were responsible for finding a way to facilitate this.

Planning for implementation of the risk project led many committee members to be concerned that their work was too little understood by staff outside the committee. Over the past year several staff had been hired and were thought to be largely unaware of the committee's purpose, membership, and work. The committee's work was not formally integrated into other program activities. While social work practitioners in the committee were concerned about there being too little acknowledgment of their research work in Social Work Departmental educational activities, a similar situation existed within the AC where projects were not being presented at staff in-service meetings.

Research Committee Leadership

As the committee considered its role in the MHP, and its structure and membership, I began to consider my role as committee co-chair. The suggestion that the risk project had been awarded resources and committee time, though not voiced by most of committee members, made me increasingly concerned that my filling this role conflicted with my position as MHP Director as it concentrated too many functions and too much authority. I became concerned that my co-chairing meetings contributed to the focus on committee processes to the detriment of projects, as staff used the agenda to discuss organizational concerns because of my organizational perspective. I felt that a clearer structure, with greater dispersal of roles and more definition of boundaries between them, and with co-chairs who were focused on the committee's work, would lead to better decision-making and a more effective committee. The committee leaders could ensure that all projects were followed in the committee and could distribute resources through a more formal process that could occur outside committee meetings. Co-chairs could routinely meet with me and other managers to ensure coordination between the research committee and other organizational units.

In an attempt to have the issue discussed openly, I asked that committee leadership be one topic discussed in the November 1998 committee evaluation session. The issue received little response so I pursued it informally, with my co-chair, with management colleagues, and with committee members individually. The responses I received seemed balanced. Some thought that my presence, as MHP Director, lent credibility and visibility to the work of the committee. They were concerned that if my stepping down at the time when the committee sought greater integration with other program activities might signal that the committee work was less of a priority and might hamper integration. One senior practitioner said my role as co-chair created a "problem of power" given my role as MHP Director. My co-chair's view was that my stepping down and continuing as a member would work if the committee structure and the expectations of each member regarding participation were clarified.

I decided that a new co-chair should be selected. This reinforced my formal authority as co-chairs would report to me and legitimize the committee's function in the MHP. One co-chair would negotiate the committee's overall resource allocation in operational management meetings. Together the co-chairs could determine the allocation of resources to individual projects. If a more formal contract outlining the expectations of membership was developed, co-chairs could meet with individual members and their supervisors to determine how much time could be allocated to them for project work. The development of criteria for accountability regarding an individual's participation could also occur outside the committee meetings using the existing supervisory structure. By moving these "managerial" functions out of committee meetings the committee could become focused supporting practitioners' PBR work.

6. The Research Committee: Begins to Reorganize - Spring 1999

In February 1999 the research committee chose a new co-leader. This practitioner, who was a team leader, participated in the operational management group and had led the development of the FamQuest. In the next months the committee's work focused on helping each project define an endpoint and planning for completion.

In March 1999, a number of recommendations regarding rethinking the committee were made by the co-leaders and presented to the committee. Following this, the co-leaders began to meet with me to revisit the committee's mission, and to rethink its organization and methodology. A plan for restructuring was developed in the summer of 1999, after this case study had ended. I will describe it in Chapter X. However, in the spring of 1999 the following recommendations, that formed the basis for the final plan, were presented to the research committee members.

Recommendations for Restructuring the Research Committee: March 1999

Integration of committee activities with other organizational processes

- The research committee's work should be more formally integrated with other program activities, including program development, program administration, program evaluation, staff development, the setting of individual staff members' work scopes, and the performance appraisal process.
  - The research committee composition should ensure representation that reflects all MHP program areas and activities.
  - Formal feedback loops should be created to connect the research committee with operational management meetings.
  - Committee membership should include all levels of staff, including those in key program and operational roles to help ensure that the research committee is integrated with other initiatives.
  - The research committee's work should be routinely included in continuing education efforts, in-service training and other staff development efforts.
  - The PBR approach should be taught as part of the continuing education program, during staff in-service training sessions.
  - The development of a formal research agenda integrated with operational management priorities should be considered, though the committee should also continue to support individual staff research interests.
  - Research participation, when practitioners engaged in it, should become

part of the individual participant's performance appraisal process, like any other work activity, with annual performance targets set in relation to participation and project work.

Committee focus and activity

- The structure and use of committee time should be rethought, with consideration given to smaller forums to conduct project work, and with careful planning to keep projects on schedule in order to enhance the group's effectiveness.
  - Routine committee meetings should be product and project focused.
  - Committee co-chairs should meet routinely and separately to plan committee agendas and review committee functioning.
  - Two full committee meetings a year should be used for the whole membership to evaluate progress and to plan.
  - Committee chairs should meet individually with members to plan for project time frames, assess project progress, discuss resource needs and plan for focused committee presentations.
  - A small group, project-focused approach should be used as the committee's growth would make it an unwieldy vehicle for project work.

Participation by committee members

- The Committee should have a more formal contract regarding membership responsibilities and participation by members. Current members who were not contributing would be asked to become active in projects or to drop from the committee. Members should have:
    - Clear expectations of what each one's contribution should be - including project participation, and the development of project plans with clear time frames for completion.
    - An allocation of time set aside for project work.
    - Performance goals that reflect committee participation.
    - Appropriate resources, with this determined in discussions between them and committee leaders.

Resources and resource allocation

- Greatly increased resources are needed to support project work to provide didactic educational sessions within the committee and for the MHP staff as a whole.
    - Consultant time should be increased and should include research supervision, training in SPSS software use, and teaching and advisement regarding writing and presenting.
    - Research consultant time should be made available for the initial conceptualization and planning of all projects.

  - Resources for the research effort as a whole should be negotiated annually with the MHP Director.
  - Resources should be allocated to individual projects in a planned way by committee co-chairs and negotiated between them and project participants.
  - Development of a research "agenda," coordinated with other MHP program development priorities, should help guide resource allocation.

Committee leadership

- Committee leadership roles should be clearly defined and should include: facilitation of the committee, managing consultants and resources, helping individuals in the organization of their projects, and helping the members to establish time frames for completion of projects.
  - Committee co-chairs should plan and run the committee meetings
  - Committee co-chairs should work with individual members to develop concrete steps and plans for the completion of the projects.
  - A division of labor should be considered in committee co-leader roles.
  - Committee leaders should be involved in the evaluation of research progress and should be consulted in the performance appraisal process.

Next Steps in the Research Committee Redevelopment: Spring - Summer 1999

Between March 1999 and April 1999 several changes were undertaken. I obtained funding for increased consultant time through "one-time" funds on an MHP grant. As a result more resources were made available to the research committee over the next months. This included a fivefold increase in PBR consultant time from twelve to fifty hours for the year. A second consultant was hired for twenty-five hours a year, to provide training and technical assistance on the use of SPSS software for data-analysis. With the committee focusing on completing its existing projects it identified a need for a consultant to mentor staff in presenting their work. The Social Work Department responded to a request for help by making available a senior faculty member as a consultant to help staff prepare presentations and papers.

Three practitioners left the committee, one for another agency. Six new members joined, including the HIV team leader, a psychiatrist, three health educators, and a social work practitioner. Three new projects were initiated. The first was an efficacy study of an intervention model for community and school-based risk-reduction through health education. The second was a study of the relationship between sexual abuse history and contraceptive practice in sexually active adolescents. The third study, which was the first new project to utilize the AdQuest, was initiated independently by a social work practitioner who afterwards joined the research committee.

This practitioner adapted the AdQuest for use as a screening tool in a vocational placement program. He and another social worker, who enrolled more than one hundred adolescents each fall in that program, were looking for ways to enrich their enrollment process. Lacking the time to provide a comprehensive psychosocial assessment to all enrollees, he modified the AdQuest to create a screening tool. In the fall 1999, this would be used as the program's primary assessment method. Pre and post intervention measures were added.

In a similar initiative that occurred during the same period, the research committee was asked to give technical assistance for another agency's competitive funding application for a new after-school program. A screening tool for high risk behaviors was required as part of the application. With my assistance, staff in this agency modified the AdQuest for use as a screening tool in a non-clinical setting and, though credit does not belong to the modified AdQuest, they were successful in their application. This agency has not yet implemented the instrument due to concern about its capacity to respond to the needs that might be identified by the questionnaire.

By May 1999, the committee consisted of five social work practitioners (two of whom were team leaders), three health educators (one who was a program coordinator), a psychologist (who was also a team leader), a psychiatrist, a social work supervisor, and myself. The presence of new members and the availability of additional resources led to a brief period of tension regarding resource allocation. Tensions arose concerning the commitment of newer members in comparison to "flagship members." Two of the new members were social work practitioners who were doctoral candidates and some suspicion was expressed about their motivation in joining. However, the voicing of this concern also suggests that the research committee, despite its reorganization, was truly established.

In March 1999, as the committee began to restructure, planning began within the AC Senior Management Group to fund a proposed AC Research Unit (ACRU). As I described in Chapter IV, this had long been an AC goal. The primary aim of this unit was to develop the academic platform within the Department of Adolescent Medicine, the Medical School entity that was synonymous with the AC. Recruitment of an ACRU Director also began at this time.

Although the knowledge that the ACRU was being developed did not directly affect the research committee during the period in which this case study was conducted, it served to highlight the scarcity of resources that had been available during the first years of the research committee's development. Initially it led to some discussion of why, if resources were available for a research unit, were resources not available for the committee. Discussion of the committee's relationship with the ACRU led to hesitancy about involving the research committee. Committee members discussed the PBR model and their interest in ensuring that it was not replaced by RBP approach. The proposed ACRU also offered the promise of new resources being made available and increased the interest of committee members in having a more formally structured committee. Even so they made clear that they wanted to maintain the integrity and identity of it. These can be interpreted as signs of the committee reaching the program stabilization phase.

7. An Analysis of the Implementation Phase

The implementation phase was not complete in June 1999. It was entering its second stage as all three MHP teams began to experiment with implementation of the AdQuest and FamQuest. However, the experience had taught that the risk project could not it fulfill its goals and be stabilized within the MHP practice without a redefinition of the committee's relationship to program management and development overall. To date, the risk project had a significant impact, not only on the research committee but also, on thinking within the MHP's operational management group regarding the use of clinical information and the need for a clinical information system.

Before I describe the lessons learned from the implementation phase, I will summarize the chain of implicit assumptions that were operating as the phase began. How did the committee frame the problem of implementation? Members became involved in two sets of assumptions. The first set related to committee members deciding that they must assuage colleagues worries about clients and client engagement. The second set of assumptions related to their view of how best to engage colleagues in a dialogue about the project. I will discuss each in turn.

Committee members believed that practitioners would have both a natural interest in the project and concerns about implementing it. In framing a workable problem and choosing a methodology for action a series of assumptions were made, though not iterated. The first was that practitioners' concerns about the project would be identical to those experienced by practitioners on the research committee during the evolution of the project. Thus the initial problem was framed in terms of whether client engagement would be compromised, not in terms of how practitioners might react to the introduction of assessment instruments into their practice.

The committee decided to test the AdQuest in practice, piloting the AdQuest with their own long-term clients, so as to address any problems encountered and reassure MHP staff. They would demonstrate to their colleagues that the AdQuest would not harm the treatment relationship and might even help engagement and clinical discovery. They led by example, the first time in which they had truly been able to "mentor" colleagues. Then, reassured and excited by their discoveries, they focused on further refining the AdQuest rather than exploring how it might actually be experienced by practitioners who were relatively unfamiliar with it.

Committee members knew that other MHP practitioners would need to discuss their concerns about the instruments. Their implicit assumption was that the way to do this was to expose colleagues to an implementation experience so that these practitioners would undergo an experience of exploration, experimentation and discovery similar to that the committee members had undergone during the pilot phase. The committee should not try to impose a practice model on staff. These assumptions reveal the committee members' respect for the organizational culture - as one in which practitioners should "autonomously" be allowed to learn - and recognition of the committee's proscribed relationship to the MHP as a whole.

After stage one was complete, committee members were well aware of the limitations imposed on the implementation process by the informality of their approach. The explicit assumptions operating within the committee were now challenged. In responding to these challenges the committee was able to adapt through the creation of a new mission, committee structure and definition and a plan for the future. I will describe the key elements in committee philosophy and functioning that were questioned and revised.

Research and Practice

In each of the previous phases I have described how lingering concerns about research affected the project. When they were identified, the exchange between research and practice principles that ensued strengthened organizational practices. When they went unspoken or unaddressed they sometimes surfaced as a preoccupation about the impact of the project on clients. Examination of the initial implementation risk project experience led to the committee openly to discuss its own approach to research, and the underlying feelings about research that many practitioners had. Many practitioners on the committee revealed that they felt unskilled in research methods, isolated in their project work, and unprepared and unclear about what was expected of them. Many members felt poorly prepared to use the committee process resulting in an ineffective use of committee resources and time. In turn the committee process had not helped them feel sufficiently solid in their project work.

The committee was clearly not structured in a way that best supported their efforts and was not adequately resourced. This learning contributed to restructuring and to the planning that I describe in the final chapter of this study. A goal of this planning process was to move practitioners and practice to center-stage.

The Formal Research Committee Model versus the Actual: Committee Members as Non-Expert Mentors or Advocates

The implementation experience underlined the committee's need to overhaul or discard its original model. The committee's formal embrace of the non-expert mentor model had never been actualized. Although some practitioners outside the committee had been initially involved in projects, committee members were, mostly, working alone to advance them. Considerable time and effort had been spent discussing how to motivate and involve staff and an informal advocacy model had developed but had gone unrecognized. The committee decided to discard this model and develop a different mode of working by first revising its mission.

The Research Committee's Relationship to the Mental Health Program: A Search for Better Integration through a More Formal Role

The research committee also began to reexamine its relationship to other MHP activities and to seek more a formal definition of its operational role. Implementation, even in a limited form, had drawn attention to this need. It had become evident to many committee members that, to establish a project on the scale of the risk project successfully, the committee's work must be well integrated with administrative, supervisory and clinical accountability mechanisms. An assumption that the committee's work was integrated into management activities, because of my presence, was shown to be unfounded and my stepping out of a leadership role within the committee meant that this interface had to be explicitly defined.

Further support for integration was fueled by the committee's discussion of the lack of rewards and the need for more visibility, within both the MHP and AC, for the research activities of its practitioner members. This was a particularly potent factor for many practitioners on the committee who sought formal recognition and rewards for their efforts that had gone largely unrecognized because the committee's work was not widely visible. Formalizing the expectations and rewards of committee membership through their inclusion in practitioners' performance targets and daily work scope would provide a push toward better integration and coordination of committee activities with supervision and program management. Ensuring that continuing education and staff development efforts gave more visibility to the committee's work was another argument for better integration.

A Change of Approach: Formalization of the Research Committee and the Development of a Research Agenda

By the spring of 1999 the committee was committed to more formally defining its role, its structure, the meaning of membership, and its relationship to other program subsystems. These included operational management, practitioner-members' overall work scopes and job responsibilities, supervision and performance evaluation, staff development and continuing education and so on. Some committee members also expressed the opinion that there should be a programmatic PBR derived research agenda for the MHP. This would, in their view, provide a focus for the committee and enable it to evaluate its priorities and ensure that its efforts were linked to other program development efforts. Having a clear agenda related to program goals would, it was said, help in the allocation of resources and staff time to projects. This was a very radical departure from the committee's long standing commitment to incrementalism, volunteerism, and informality.

Conclusion

In my earlier analyses of the pre-rational, initiation and program contact phases I identified explicit and implicit assumptions that shaped the research committee and the risk project. Assumptions about the organizational culture - particularly the view that clients should be carefully protected from research and that nothing should be done to disrupt the formation of engagement of clients - as well as committee members' concerns about research - had shaped the committee's *modus operandi* throughout these three preceding phases. These factors had contributed to an approach based on of voluntarism, informality and incrementalism. I have also described how the committee's official "model" - that it would serve as a group of non-expert practitioner-mentors - clashed with its actual practice. As the implementation phase began these assumptions were examined for the first time - as was the approach the committee had developed over many years.

In describing the pre-rational, program initiation and program contact phases in the preceding chapters I have described how the committee framed the challenges it faced. Cornelius (1998) described the characteristics of the naming and framing process as follows:

> [T]he investigator is within a context where few variables are under his direct control. The actions taken and the knowledge gained result from a continual flow of "surprises" to which the practitioner responds in a largely unanticipated ways to real-life circumstances he confronts (1996, p.43).

The committee's long history of reluctance to impose research on MHP staff and its unreadiness to prescribe a practice methodology for integration of the risk project into practice was shaped by several forces. In part it was a response to the perception that most practitioners were unfamiliar with research and might be research-aversive. It also may have reflected members lingering uncertainties about research skills. However, the committee's style of informality, voluntarism, and incrementalism also was a reflection of aspects of an organizational culture in which practitioner autonomy was highly valued and informality was less the exception than the rule.

By the end the implementation pilot, I was aware that the informal approach taken toward implementation had imposed limitations that reflected the committee structure. I was also beginning to examine how informality might by synchronous with "organization cultural" factors that related to client engagement and assessment. I was increasingly questioning whether the valuing of practitioner autonomy - so evident during implementation - reflected only the practice ideologies and professional values of the MHP practitioners or served some greater organizational purpose.

Embarking on the risk project set the committee on a path that eventually challenged the appropriateness of the committee's informal approach. I began to realize that a measure of culture change might be necessary if the risk project was to be successful, as it would require more formalized practices. In the next chapter I will return to this issue, as it may be one of the biggest challenges for the future.

Chapter X. Conclusion:
Looking to The Future and Program Stabilization

1. An Overview of the Chapter

This concluding chapter is intended to achieve three ends. First, I set out to evaluate the risk project and the research committee as to their achievements and condition in June 1999 when the study ended. Second, I consider the future of each of these efforts. Third, I discuss the implications that this study has for social work. The chapter is organized in the following way.

Section two outlines Bielawski and Epstein's (1984) conceptualization of the program stabilization phase in which the program goal is to institutionalize an innovation if it has been successful. I then assess the risk project in terms of the goals that the research committee had for it. Though it had not yet achieved the conditions necessary for program stabilization, my colleagues and I concluded that the risk project was a partial success and that it should be continued and strengthened. Furthermore, we thought that this might be achieved through a more formal research committee effort and the development of a clinical information system.

Section three presents the revised mission and plan for restructuring that emerged from the research committee between June and December 1999. This plan focuses on the creation of a more formal committee structure, and the coordination of committee activities with other MHP subunits. Included in it are guidelines for legitimizing practitioner research activity within a practitioner's work scope and performance appraisal process, the plan for a more project-focused committee structure, and plans for staff development.

Section four uses Bielawski and Epstein's (1984) framework for an evaluation of the research committee effort, effectiveness and efficiency, discussed in terms of its several goals and aspirations. The first of these was its goal of fostering research interest and participation among MHP practitioners by having committee members mentor their colleagues. This goal was finally abandoned in June 1999, the efforts to achieve this goal had failed. Other areas in which the committee was more effective are discussed. These include the creation of PBR projects, the development of committee members' knowledge, and the enhancement of the MHP practice. I then discuss how PBR was an effective methodology for creating organizational learning processes, despite the inefficiencies created by the committee's "mentoring" model and informal relationship to other MHP activities.

I end the consideration of the committee's efficacy by describing the impact of the committee effort on my own "viewpoint" as the program director. Though for me committee participation was an enriching experience overall, I focus particularly on my insight into the previously unspoken challenges that the practice setting presents to practitioners who are engaged in research. I describe the resulting efforts that I initiated to clarify the core professional competencies required, by the nature of the clients and service delivery system, of social worker practitioners working in the AC.

Sections five, six and seven discuss the implications that this dissertation has for the field. Section five addresses the benefits and hazards of taking formal approaches to research development in practice settings, and under what conditions informal approaches might be best. Section six focuses on the insights I gained regarding the function of informality in the clinical assessment and engagement process, and practitioner "resistance" to standardization. Garfinkel's (1967) ethnomethodological approach is utilized as a framework for interpreting the meaning of informality and practitioner "idiosyncracy" in terms of the everyday world of practice, and to explicate its organizational purpose.

The dissertation concludes with section seven, in which I discuss the unique viewpoint that this retrospective case study offers - a practice perspective on the research-practice divide - and the two major implications it has for practitioners and researchers. First, I discuss this study's novel perspective regarding the importance of understanding the nature and functions of informal, everyday practices in agency settings. Further investigation of these aspects of practice is essential if the introduction of evaluation and research methodology into practice is to be successful. This issue has been neglected in the practice-research literature. Second, I offer a fresh perspective on the debate about whether practitioners integrate research findings into their practice. My conclusion is that this debate has been overly focused on the impact of published studies on practice and has neglected to consider the ways in which practitioners and managers might utilize less rigorous, but nonetheless research-derived methods in practice. I suggest that a lopsided view as practitioners as research-aversive has resulted. Studies conducted "from the ground, up" as this one was, might be used to consider the utilization of "research-like" approaches in management and direct practice.

2. Program Stabilization and the Risk Project: June 1999

In their extension of the Differential Evaluation Model, Bielawski and Epstein (1984) use Patti's (1978) concept of stabilization to describe the phase of Program Stabilization as follows.

> In this fourth stage the program has become institutionalized. 'The major tasks during stabilization are achieving greater internal rationality and efficiency and maximizing services in the interests of program goal attainment' (Patti, 1978, p. 280). Program directors are concerned with maintaining the capacity of a mature program while simultaneously avoiding the dysfunctions that can undermine these capabilities. These dysfunctions can take the form of staff resistance to needed changes, a focus on organizational maintenance that overshadows service needs, and/or a widening gulf between organizational policies and programmatic needs (Patti, 1978) (Bielawski & Epstein, 1978, p. 17).

By June 1998 the risk project had clearly not yet achieved the maturity and integration into routine organizational activity that characterize program stabilization. Implementation was exploratory. Most MHP practitioners were now experiencing the AdQuest and FamQuest in their assessment practice for the first time. They had shown little uniformity in their use of the instruments and the research committee had not yet committed to a specific model for the routine use of these instruments in the assessment process. The work that this would require would include developing procedures and protocols for the AdQuest and FamQuest's use clinically and within the treatment review teams. Though these tasks were yet to be done, committee members were committed to accomplishing them. Systems for distributing the information generated by the project within the MHP were not yet developed. With these efforts still exploratory, I considered the risk project to being still in its "adolescence" rather than having achieved maturity.

Before considering how to institutionalize the risk project, it was appropriate to determine whether it should be continued. What had been achieved and what remained to be done? What changes - if any - should be made? In June 1999, my research committee colleagues and I believed the risk project had been only a partial success in attaining the goals we had originally set in the fall 1996. However, we could identify no indications that it could not live up to our expectations if we now formalized the research committee's role within the MHP. To describe what had been accomplished, I will discuss the risk project's progress in terms of its original goals and then discuss other results that had not been envisioned when these goals were first developed.

The Risk Project's Original Goals

Between October 1996 and November 1996, when the risk project was evolving as one component of a proposed "MHP data base," two sets of goals were iterated for it. Five broad, overlapping and interrelated goals that were generally *programmatic* in their focus were formulated in October of 1996. They are listed below. (In November 1996, as the focus narrowed to client assessment, three more-specific goals were articulated to clarify the original five goals. I have included them as a subset of the October goal two). The goals were that the project should:

(1) Provide baseline information on client risks and expectations of services.

(2) Enhance clinical assessment practices by developing uniform standards and methods, including identification of risks. Specifically:

(a) Lead to more uniform and pertinent clinical information regarding client risk behaviors.

(b) Lead to more uniform and rigorous clinical assessment processes.

(c) Enhance practitioners' understanding of whom the clients are, why they are coming and what they want from services.

(3) Enhance program development.

(4) Create a beginning data base for future PBR studies.

(5) Help preserve existing grant funds and help in the development of new service grants through the more systematic collection and reporting of information.

The Risk Project's Accomplishments

How had the risk project measured up to these original goals? Goal one had been to provide baseline information on client risks and client expectations of services. By June 1999, the risk project had shown that it was an effective, efficient and rigorous way to generate uniform and clinically relevant information about clients. This information now provided the MHP with the capacity to describe many psychosocial, risk-related characteristics of the client-population that had not been routinely recorded. For the first time ever the MHP had readily available, uniform data on all clients admitted after June 1999. However, systems were not yet in place for the distribution of this information to MHP staff or to learn how it might be used.

Goal two was to enhance clinical assessment practices by developing more uniform standards and methods, including identification of risks. Specifically the project should (a) help develop more rigorous and pertinent clinical information regarding client risk behaviors; (b) lead to more uniform clinical assessment processes, and; (c) enhance practitioners' understanding of whom the clients were, why they were coming and what they wanted from services. Though these goals had not yet been accomplished, committee members considered them to be both desirable and achievable. They saw several indications that suggested the risk project could enhance assessment practices once it was fully established.

As I described in the last chapter, stage one of implementation had shown that in problematic cases practitioners had utilized the AdQuest in several ways. Where there were strong anomalies between what clients revealed on the AdQuest and in session, or where clients seemed unconcerned about risks that they had revealed on the AdQuest, practitioners had used the AdQuest to explore the client's perceptions of presenting problems and behaviors and to discuss differences in viewpoint between client and practitioner. Despite the lack of routine and standard methods for reviewing the AdQuest and FamQuest in the team, as part of treatment planning, experience suggested that the instruments could enhance team effectiveness. The information obtained by the instruments had been used by the team in the most complex and difficult case presentations. Committee members agreed that the AdQuest and FamQuest were providing relevant and useful information about clients, but that the routine uses of this information by individual practitioners and in the team review process would depend on formal implementation procedures. Clear expectations for use of the information in team case reviews would have to be established before the project's potential for enhancing clinical assessment could be fully realized.

Having standard, readily available information about individual clients had created the capacity for new monitoring and quality assurance initiatives. However, these were not being considered at this early stage. It was clear to the committee that to use the risk project for quality assurance purposes at this time would lead to the perception that the instruments were primarily administrative monitoring tools and result in only superficial compliance. Committee members felt that quality assurance initiatives based on the risk project should be developed only after the project was well established, with team members receiving appropriate support and guidance regarding the clinical use of the instruments. Furthermore, they believed that this should be done collaboratively by team members based on issues identified by the team.

Goal three was that the risk project should enhance program development. Small, yet positive, indications that the risk project could enhance MHP practices had been seen during the program initiation and program contact phases. Attention had been drawn to inconsistencies in the way practitioners handled issues related to client confidentiality and consent for treatment. Hopes that the risk project would enhance program development extended to the evaluation of existing services and the creation of new services. The loss survey, initiated in 1995 and described in Chapter VI, had led to the identification of a need for services for adolescents suffering from unresolved bereavement issues. As a result a support group had been successfully developed and continued to run in 1999.

Still in its adolescence, the risk project had not yet led to the formation of new service initiatives. However, by June 1999 122 adolescents had been surveyed and the AdQuest had already drawn attention to two issues currently overlooked in assessment - the experience of racism and the importance of work in clients' lives. Of those clients assessed, 51 clients (42%) responded that they had experienced racism. Eighty-four adolescents (69%) reported that they were not working and wanted to. It appeared that more should be done to explore and address these issues in the assessment and through services. Twelve adolescents reported that they had problems balancing work with other responsibilities. With full implementation just beginning, and without systems in place to distribute and analyze the information generated by the project, it was too early to assess its contribution to program development. Nevertheless, the conclusion reached by the committee, was that the project showed considerable promise.

Other promising signs that the AdQuest might help in program development could be found. These did not directly result from the clinical information that the project was generating but from the AdQuest being viewed as an exemplar for development of screening tools that could help practitioners in other program areas to work more efficiently. The AdQuest had been used as the basis for a new screening tool created by a practitioner in the MHP's vocational mentoring program with implementation planned for the fall 1999. This new tool was designed to enhance client enrollment by adding an assessment component that had not previously been conducted due to the high volume of clients enrolled each fall and the lack of social work coverage. The screening tool was developed to identify clients specifically in need of assessment for mental health services. The AdQuest had also been adapted for use as a screening tool in a new, after-school program being developed by a local settlement house, although this had not yet been carried out.

Goal four was to create the first component in a data base for future use in PBR studies. By June 1999, the project was beginning to generate substantial amounts of information. However, systems were not yet developed for making this information available to others outside the research committee and so its potential uses that had not yet been explored. Committee members were hesitant to consider using the risk project data at this time for two reasons. First, the instruments were not yet firmly established as clinical tools and it was important to the committee that this should be accomplished before the risk project was used for research purposes. Members had taken a similar position regarding quality assurance initiatives. Second, the committee's intention was that information generated by the project would be for use by all MHP staff and, until systems were developed to make aggregate data available, committee members were not comfortable using it that way.

Implementation of the risk project had done more than begin to generate information of use for future research. It had shown that questionnaires could be routinely used with both long-term and new clients without any apparent negative effect on their engagement in services. It had drawn attention to the need to rethink and overhaul the research committee's approach to research to make it a more effective vehicle for development of PBR studies. I will return to this.

Goal five was that the risk project would help preserve existing grant funds and in the development of new grants. By June 1999, some minor successes were evident. Discussions of the project with funders, even before it was implemented, led to a small increase in operating funds, by $80,000 annually.

At the same time, the MHP received a federal Centers for Substance Abuse Prevention Award based, in part, on the approach to enhancing service effectiveness that the risk project represented. This approach involved providing services while simultaneously evaluating the fit between services offered and the client-population served. In my experience, many funders of services want self-evaluation, but are not willing to fund research. In this instance PBR provided a service-based, funder-friendly methodology. Descriptions of the risk project methodology, and copies of the instruments along with preliminary data, were included in several funding applications submitted in the spring and summer of 1999.

Most notably, I wrote a competitive application to the state seeking funding for, and designation of, the AC as the Downstate Regional Center for Excellence in Adolescent Health. The proposed AC Center for Excellence would provide training on service design, evaluation and staff development to designated community-based partnerships. The AdQuest and FamQuest were included as exemplars of assessment and case-finding tools.

Early in 2000, the AC won this award, and was named the Downstate Center and awarded a $425,000 in new funding for each of three years. Though credit for this achievement belongs to contributions from many different elements of the AC, the risk project demonstrated the AC's commitment to developing innovative tools and to evaluation methodology. As the AC senior managers considered future applications, for research and service grants, the risk project provided an exemplar of what should be done on a wider scale to develop preliminary data.

Looking Toward the Future of the Risk Project

In June 1999, the research committee still had far to go in fully implementing the risk project. By now it should be clear to the reader, as it had become to me and my colleagues in the research committee, that complete implementation now depended on improving the research committee's planning and coordination with other program development efforts. Though the project had made only modest advances, committee members agreed that it should be continued. Until June 1999, nothing in the experience of the risk project suggested that it could not achieve its goals and the problems in implementation highlighted the need for a more structured and directed effort.

Patti (1978) notes that in the stabilization phase of any program the director's tasks should be focused on maintenance of the program's capacity and avoiding the dysfunctions that can result from the institutionalization of an innovation. The most common problems in stabilization relate to the formalization of the innovation and the tendency for its original purpose to become displaced. The most likely problems at this stage are an overemphasis on policies and procedures to the detriment of client needs, and staff resistance to continued development and change. Yet in June 1999, I was still concerned with the problem of how to create policies and procedures related to the institutionalization of the risk project.

I had come to believe that the institutionalization and stabilization of the risk project would first require formalizing the research committee's programmatic role, specifically its relationship to program and staff development efforts. The episodic and slow nature of the project's progress had mostly been a result of it having to compete with many other organizational initiatives that required sustained attention and effort. Moreover, It had never been "owned" either by the research committee or by the MHP operational management group. This underscored the need for a clear plan for research development, linked to program development priorities, to help guide the MHP's development efforts and to ensure better coordination between these efforts and faster completion of PBR projects. By underscoring the benefits of a more formalized research development effort, the risk project had contributed to organizational learning regarding program development.

The risk project had shown that it could generate information that was rigorously and methodically obtained. Nevertheless, this information had not, yet, dramatically affected program practices. A strategy would be necessary to create an environment in which the use of information derived from PBR was routine for both practitioners and managers. I concluded that, to achieve this, the risk project should be defined as one step in the development of a clinical information system that would provide a planning framework and conceptual infrastructure for this strategy.

In my view the creation of a specific risk project workgroup - now to be called the clinical information system (CIS) workgroup - would also be necessary to sustain the effort. This CIS workgroup would serve to bridge three areas of program activity - research, operational management and program development, and staff development - and its membership should reflect this. Team leaders and psychiatrists should be involved.

Another question that I considered, and discussed with management colleagues, was whether the CIS workgroup should be considered part of the research committee or operational management. Though CIS development was not a research endeavor, I decided that effort should be organized as part of the research committee though a strong link with operational management would need to be maintained. In my view, this would serve three ends. (1) It would keep the project center stage rather than have it be one of many pressing, and competing, items on the management agenda. (2) It might help define the CIS goal as practice innovation and lessen the chances that it would become defined by practice staff as a purely administrative endeavor. (3) It would continue to provide an exemplar of the utility of the PBR paradigm as a medium for infusing reflective processes into an array of organizational activities.

I proposed that the CIS workgroup should be one component of the redesigned research committee, with representation from all levels of the MHP staff. It would coordinate the development of the CIS with other initiatives that related to it. One example, was the effort to redesign the service record. Having been suspended in 1997, this was now being resumed. Its goal was to ensure that the service record be made simpler, easier and faster for practitioners to complete, provide easier access to available information, and be consistent with the AdQuest. This was just one example of how formal relationships might be developed with the CIS workgroup integrating aspects of management operations, research activities and the daily practice, within the context of formal and integrated program development and research development agendas.

To summarize, though it was clearly still a work in progress, the risk project had drawn attention to several organizational imperatives. (1) The research committee's informal structure and approach no longer fit well with the MHP's needs. The committee's role and work should be made more formal to bring it into line with other MHP program structures. (2) Better coordination was needed between the research committee's work and program management, program development and staff development, if research-derived information were to be routinely used to shape practice. (3) An MHP research agenda, with clear priorities that related to program planning overall, should be developed and should help guide decisions about research efforts, allocation of practitioner time to nonclinical activities, and resource allocation. (4) Development of a CIS should be undertaken to provide the framework for creating an environment in which information - derived by rigorous and methodical means - would routinely and commonly used to influence practice.

3. A Plan for the Future of the Research Committee and a Clinical Information System: June - December 1999

When this case study ended, in June 1999, there were many indications that the research committee had entered the program stabilization phase. Members had identified - what Patti (1978) terms - the "dysfunctions" that had limited the committee's capabilities. The committee had examined the "gulf" between its practices and programmatic needs, and it began to revise its mission as a result. Between June and December 1999 a plan emerged from the committee and a new structure was proposed. These were intended to facilitate the continued development of the risk project, under the rubric of a CIS, and to integrate research and program development activities. I will highlight key elements of this plan.

A Revised Research Committee Mission Statement

"*To help members develop practice-based research that informed and affected program and practice.*"

This revised, more direct and simpler mission replaced the committee's original mission to have members mentor other practitioners and foster research interest and projects among MHP staff. Though the difference may seem subtle, the change was intended to affect committee members' activities in three areas. (1) It should shift the burden of integrating the committee's work into the MHP program from practitioner members to ***committee co-leaders and the MHP operational management group***. (2) This integration effort should be done outside routine committee meetings, to change the committee focus from organizational processes and arrangements within the MHP, to research projects aimed at enhancing services. (3) It identified committee members as the intended *recipients* of the committee effort - of support, training, and consultation so as better to equip them for research project work.

A Plan for the Research Committee

Following are the highlights of the plan that emerged from the research committee during the fall of 1999.

1. Planning and coordinating of the research committee's effort with other MHP activities.

i. Development of an MHP *research agenda* will be conducted through delineation of MHP program development / research priorities. This will be carried out by research committee co-chairs, in consultation with the research committee consultants, the MHP director and MHP Operational Management group (MHP medical director, social work supervisor, the MHP team leaders, primary care services and MHP team leaders, staff psychiatrists and the group services coordinator)

ii. Ongoing *coordination between the research committee and the MHP Operational Management group* will be improved through inclusion of research committee activities in the ongoing operational agenda, inclusion of MHP team leaders within the research committee, and through monthly reports on committee activities in operational management meetings.

iii. Ongoing *coordination between the research committee and the MHP in-service training committee* will be initiated to ensure inclusion of research committee presentations, and training on PBR, in ongoing staff development efforts.

iv. Research projects that require resources, including the allocation of staff time for research activity, time will be prioritized based on the research committee agenda. The potential benefit to clinical program areas will be one criterion for determining whether time is allocated to practitioners for project work.

2. Research Committee Membership

i. Research committee *membership will be expanded to include representation* from all MHP program areas and the MHP Operational Management group.

3. Research committee participation

i. Research committee membership will remain *voluntary*.

ii. Research committee members will have a more *formalized* agreement with the committee co-chairs regarding the expectations of committee participation, the time allocated to research work, and the accountability for, and recognition of, research activity.

iii. Committee activity will be formally included in the individual members' *work-scope and performance appraisal process*. Committee co-chairs will meet with individual members and their supervisors twice annually, to determine each individual practitioner's work-scope and time allocation, performance goals and accomplishments as they relate to research participation. The research committee will function in a way similar to existing MHP supervisory, training and program development groups.

iv. A delineation of the agency's *expected core-professional competencies* will be developed to include core expectations regarding research participation and knowledge dissemination. These core-competencies will take into account the individual social work practitioner's ranking in the Social Work Department career path, (described in Chapter V).

v. *Time will be allocated to practitioners* on the committee for research activity. This will be done in consultation with supervisor and the person responsible for coordinating the clinical service within which the practitioner works, to ensure that the research effort supports the service.

vi. Research committee members will have *increased access to consultancy*, research project supervision, and other forms of support. Resource allocation will be done by committee co-chairs.

4. Research Committee structure and activities

i. A greater *division of labor* will be used to plan and conduct various committee activities. Co-chairs will be responsible for planning and running meetings, and committee meetings will generally not be used to plan committee activities or review the relationship between the committee and other program activities.

ii. Two full research committee meetings a year will be used for a *committee self-evaluation*, to review the effectiveness of the committee, to consider its relationship to other MHP activities and to plan.

iii. Eight full research committee meetings a year will be used for *training and educating committee* members on PBR approaches.

iv. A twelve-hour training *practicum in SPSS statistical software and data analysis* will be offered in the summer of 1999 to research committee members and to those MHP practitioners interested in joining the committee.

v. Two separate committee *workgroups* will be formed to develop and conduct project work. A committee co-leader will be assigned to each. In the spring of 2000 each of these workgroups will focus on different types of projects. One workgroup will focus on studies that "use of available data." The second will focus on studies of intervention efficacy. Existing projects will be assigned to one of these groups as follows:

- *The Use of Existing Data Workgroup* will support projects that use existing data. Two existing committee projects will be assigned to this group: (1) Exposure to violence and its impact in high school students, and; (2) Exploration of the relationship between a history of sexual abuse and the contraceptive practices of sexually active adolescent females.
- *The Intervention Efficacy Workgroup* will support projects investigating intervention efficacy. Two existing projects will be assigned to this group: (1) The impact of vocational mentoring and placement on early adolescents' aspirations and self esteem, and; (2) The impact of a five-session, peer-based risk prevention-education intervention on junior high school students.

vi. During the spring of 2000, the committee co-chairs will consider whether to reorganize the workgroups based on each project's *stage of development* - for example workgroups organized around new projects being initiated, ongoing projects, and projects nearing completion.

vii. A third workgroup will be formed - *the Clinical Information System Workgroup*. This will focus on (1) identifying and developing elements of a CIS within the MHP, and (2) developing protocols and procedures for institutionalization of the risk project. This group will consist of interested practitioners and members of the MHP operational management group, including the MHP Director and the psychiatrists and team leaders.

5. Integration of research committee activities with MHP continued education, training and staff development efforts

i. Current *in-service training* staff meetings (one hour monthly) will be supplemented by an additional hourly session monthly that focuses on PBR, and that integrates committee projects as exemplars of PBR applications. The PBR consultant, will begin this effort by conducting three, one-hour sessions over a three-month period focusing on PBR methods and applications. Committee members will co-present at these seminars to integrate project work into in-service training.

4. An Evaluation of the Research Committee: The Implications for Practice

Bielawski and Epstein (1984) state that the aim of evaluation in the stabilization phase is the assessment of the efficacy of the innovation and the consideration of alternative modes of operation. They identify three constituents in the evaluation of efficacy: evaluation of effort, evaluation of effectiveness and evaluation of efficiency.

Effort is the time and activity dedicated to the innovation as well as the cost of the rewards and incentives involved in it. The MHP research committee effort included the time that participants had spent in committee meetings, the cost to the MHP in terms of practitioners' engagement in projects, (including productivity loss from direct services), and the effort spent in communication and collaboration between the committee and other organizational subunits. Bielawski and Epstein (p. 20) define effectiveness as the extent to which the innovation reaches its objectives and the quality of its working relationship with other organizational subsystems. Evaluation of efficiency can be approached in two ways. The costs of the innovation can be compared with other similar innovations, and the effort expended in accomplishing the innovation's goals can be compared with that expended in maintaining its continued survival.

Two elements that shaped the committee were (1) the structure it chose to conduct its work, i.e., the mentoring model that defined its relationship to the MHP, and (2) its choice of PBR as its methodology. In the committee's five-year history the effects of these two elements were highly intertwined. However, while PBR offers a methodology to use research principles to enhance practice, it does not prescribe a single *model* for doing so. Therefore, I will first discuss the overall efficacy of the committee, and discuss PBR separately at the end of this section.

I will briefly consider the committee's effort, effectiveness and efficiency, in that order, and then will discuss its overall efficacy in regard the aspirations that I had for it. Bielawski and Epstein also suggest that evaluation include the comparison of the innovation with other efforts that aspire to similar ends (p. 20), so I will begin by describing two research development efforts reported in the literature.

A Comparison of the Research Committee Experience with Other Models for the Development of Practitioner Research

Although many who call for greater integration between practice and research have advocated the agency-academia partnership, described in Chapter III, the MHP endeavor aspired to develop indigenous, practitioner-driven research activity. That there are few descriptions of such efforts in the literature is testimony to the unique nature of this case study. Two indigenous, committee-based models that aspired to enhance practitioner participation in research are documented in the literature and though both differ significantly from the MHP committee they serve as comparisons for the MHP experience. The first (Turnbull et al., 1988) describes a research task-force formed within a social work department in a large academic medical center. The second (Sidell et al., 1996) describes a support group approach in a smaller hospital. Though the former group did not select a PBR approach and the latter did, both groups were intended to overcome practitioners' discomfort with research and to develop practitioner research activity.

Turnbull et al. (1988) describe the formation and first two years of a research task-force among social workers in a large nine-hundred bed academic medical center. This was created via a leadership decision to have the social work department involved in academic and research activities so as to be more aligned with the mission of the host setting. Though the differences between Turnbull's endeavor and the MHP experience far outweigh the similarities, they share common threads. Both wanted research participation to be voluntary and both wanted to generate interest in research and reduce social workers' discomfort with it.

Chief among the differences between Turnbull's approach and the MHP's was the fact that most of Turnbull's social workers, forty-four in all, had faculty appointments within the medical center host setting. Although Turnbull does not clarify the institution's expectations of these social workers regarding their research participation, her effort was intended to align work activities with formal performance expectations and with the formal mission and objectives of the department, implying an institutional sanction for social worker research activity. Its goal was to make social work faculty more comfortable with research ideas and proposals. Turnbull's task force was formed in the nineteen-eighties, before the reorganization of health care and the escalating constraints on social worker activity that occurred in the nineteen-nineties. How this effort fared in the harsher environment of the nineteen-nineties has not been reported.

Turnbull's strategy was the development of a series of workshops and lectures. A PBR approach was not selected. Participants were encouraged to participate in interdepartmental collaborative projects. One strategy to reduce resistance to research participation was the recruitment of social workers with research experience and expertise, and more than twenty of these were newly hired. Turnbull stresses that her approach was highly informal, which is striking, considering that she had an overarching "formal" goal in mind, institutional sanction, and the formal inclusion of research activity in participants' job descriptions. Turnbull offers only an implicit definition of "informality": participation was voluntary and that participants were not evaluated in regard to their participation.

Despite the sharp contrast between Turnbull's effort and the MHP research committee - the latter consisting of practitioners with heavy workloads and no formally sanctioned time for research - both chose informality as a way to overcome practitioners' discomfort with research. Turnbull's group was informal by design. In contrast, the MHP's informal approach evolved gradually, but both experiences suggest that some degree of informality might be beneficial in the fostering social worker research participation during the formative phases.

Another research group effort described by Sidell et al. (1996), can be compared with the MHP committee. Sidell's group had more similarities to the MHP approach than did Turnbull's task-force. Most importantly it is comparable because it chose PBR and because the report from Sidell's group focuses on the *experiences* of its practitioner members.

The setting in which Sidell's group was formed had other parallels with, and differences, from the MHP. Like the MHP research committee, it was formed in a department that was expanding - from eleven to twenty-two practitioners. However, in contrast to the MHP experience, this group initially had much greater access to research consultancy. Sidell's effort represented a whole social work department - even if it was a small one compared with the Medical Center's - and was led by its Director. The approach chosen by Sidell's group was the one that my own group rejected. Sidell et al. chose to work on a single and specific area of service need and on one project at a time. Sidell's group hoped that their first study would demonstrate the need for a new social work service and approval of budget for a new practitioner line. Having chosen a pragmatic and instrumental strategy, they were successful. Practitioners who participated received a tangible reward in the form of an additional practitioner to share their work. Working on a specific area of service need, and on only one project, gave Sidell's committee a sharper focus than my own, which in contrast, set its sights on creating enthusiasm for research throughout the MHP and on initiating several projects at once.

Sidell's group was successful in completing one PBR project and generating two conference poster presentations and two peer-reviewed articles, following two years of work. However, this is not the primary focus of their report which is more concerned with the experiences of the participants and emphasizes three particular phenomena that were significant for them. First, practitioners tended greatly to underestimate and denigrate the research knowledge and skills that they had gained. Second, they learned - only after two years of work - that attention should be paid to role clarification and to assigning tasks to individual members so as to appeal to each one's particular skills. Given that Sidell's group focused on a single project and on developing a peer-reviewed publication, this might have been easier for it than for the MHP group, wherein numerous projects were being undertaken simultaneously. Sidell's group concludes its report by describing a phenomenon that the MHP group also experienced: practitioners became frustrated by the very slow pace of progress on projects. Sidell et al. note that this frustration took a sustained and focused effort to manage as practitioners' experience of this slow pace of development was in stark contrast to the task-focused, rapid pace of their daily practice. They report:

> Of significance for practitioners, particularly those involved in health care, is the pace at which they must perform their duties. Being results oriented in an ever-changing environment with a quickly changing caseload is a typical work scenario. The process of research takes time, and it was with dawning realization that clinicians recognized the much slower pace of research projects. Recognizing this and discussing it within the group proved to be a helpful tactic in dealing with this dissonance (Sidell et al., 1996, p. 108).

The MHP Research Committee: Effort

A continuous effort conducted over many years had been expended on the research committee and though this had not been quantified, a general picture of this effort can be drawn. The committee had met for an hour weekly during its first two years and biweekly after that. The overall research effort is difficult to quantify as it was highly episodic, with the greatest effort expended when other MHP activities most allowed. For practitioners, whose work with adolescents was highly "seasonal," times of peak client activity - the fall and spring in particular - often pre-empted project work. Routinely, most members reported spending - at most - two hours weekly in committee and research activity. The committee had not required a great deal of administrative time compared with other program development tasks and little consultant time had been utilized. The PBR consultant, had met with the committee for approximately an hour and a half monthly.

After concluding that the risk project would require a more sustained and coordinated effort to be fully realized, I decided that the committee had not involved an intensive, costly effort and that more should be done. All committee members - from practitioners to supervisory and administrative staff - agreed that a greater effort and more resources should be spent if the committee were to be more effective. This increased effort would involve the costs of allocating more research time to practitioners, a planned sixfold increase in consultant time, shared between three consultants, and a more concerted effort in staff training and coordinating with other organizational subunits.

The MHP Research Committee: Effectiveness

Bielawski and Epstein (1984) suggest two, complementary methods for evaluating effectiveness of an innovation or program. The first is evaluation of the innovation in terms of its goals. The second approach is to evaluate the innovation in terms of its influence on the pre-existing service technology. I will address both.

Several components of the committee's ambitions and goals should be considered in assessing its effectiveness overall. They are: its effectiveness in fostering research interest and participation amongst staff; its effectiveness in developing research projects; its effectiveness in developing committee members' knowledge; and, because the committee aspired to develop reflective practices within the MHP overall, its impact on the MHP's practice technology and its contribution to other forms of organizational learning.

Project Development

Structured as it was between 1995 and 1999, and with the considerable effort expended on trying to engage those who were not committee members, the research committee had been only a qualified success in terms of conducting and completing project work. The model in which committee members were to mentor colleagues outside the committee resulted in the diversion and dilution of the committee's energy toward an elusive and unrealistic end. Its effectiveness in conducting projects was compromised as a result and, as I described earlier, the "mentoring" model was dropped when the committee reorganized. Despite the limits of the committee structure, by June 1999, four PBR projects were nearing completion and three new ones were being initiated. One paper was being prepared for submission to a peer reviewed journal and several conference presentations had been made.

These projects had been slow to develop, with the loss survey and Latino immigrant study taking four years for completion. In the spring of 1999, when the committee recognized that concern about its extremely slow pace was leading to worries about its effectiveness overall, it made a concerted effort to identify the forms that "completed projects" might take. Possible PBR "products" included reports to staff, departmental presentations, professional presentations, and peer reviewed publications. Participants' pre-existing views of what a completed project *should* look like had been determined by their exposure to research publications, as they had few other exemplars upon which to draw. Published research papers, which seemed to them to represent the ideal, were not the most appropriate exemplars for the types of PBR projects that had been conducted. Identification of more appropriate, practice-based "end-products" helped mobilize them. Furthermore, participants came to see that a presentation to the MHP staff might be a sufficient end in itself or might be viewed as a step to something further. These discussions also led to the realization that modest presentations - within the confines of the MHP - might lead to the service enhancements and might be more influential on practice than presentations to a broader audience.

Knowledge Enhancement Among MHP Research Committee Participants

Sidell et al. (1996) observed that practitioners may tend to underestimate how much they had learned from PBR participation and such a tendency complicates the assessment of a PBR committee's effectiveness in developing its members' knowledge. If, like Sidell's committee, the MHP committee members underestimated how much they might have learned, they might be likely to underestimate the overall effectiveness of the committee. However, knowledge enhancement should not be assessed in terms of research skills gained by members. PBR does not aspire to train practitioners as researchers, but to enhance their practice skills through the application of principles shared by research and practice (Epstein, 1995). Its aim is to enhance practice. Thus, the MHP committee's purpose was not to train members in research skills, per se, but to enhance their skills and effectiveness generally as practitioners.

Members of the MHP research committee did express that they felt ill-prepared for research tasks and that this delayed their progress. Was this a failure of the committee to develop its members' skills, or a success in that practitioners learned to identify the help they needed? Sidell et al. note that in their research committee a division of labor had to be developed - based on members skills and interests - to ensure progress and to help each individual experience an area of competence. For instance, individual members took responsibility for key tasks such as literature reviews and Institutional Review Board liaison. Even so, Sidell's group identified a need for external research expertise and recruited two consultants from the faculty of a school of social work. Like the MHP committee, Sidell's group needed research consultants. When MHP research committee members acknowledged their own lack of skills, they did not view this as a personal failing, but as a need that the committee should address by providing outside experts.

The evidence suggests that most, but not all, MHP research committee members experienced the committee as an effective vehicle for knowledge development. The changing metaphors used to refer to the risk project can be interpreted as signs of a growing comfort with PBR among committee members. The evolution of the nomenclature used to define the project - from "mental health database" to "risk study" to "risk project" to "clinical information system" - is evidence that it was increasingly accepted as syntonic with practice. A powerful metaphor of the AdQuest as a clinical "engagement tool" emerged during the initiation phase. This shows that the practitioners' growing capacity to bridge research and practice principles and an indication that the committee was an effective vehicle for staff development.

Since the committee had been in existence for more than four years the stability of its membership is another indication of its effectiveness in developing participants' skills. As I described in the last chapter, two members left the committee in the spring of 1999. They said that they could not afford the time and effort they spent in committee meetings despite the intellectual stimulation they received. However, the other six members stayed engaged, as they had done for more than four years and the committee membership expanded to twelve in the summer of 1999. Overall, I conclude that the MHP committee was effective in continuing to meet the needs of a diverse group of professional staff who wanted the opportunity to study their own practice.

The Research Committee's Impact on the MHP Technology and Services

Bielawski and Epstein (1984) suggest that one approach to evaluating the effectiveness of an innovation is to examine what adaptations to the pre-existing service technology resulted from it. In addition, the evaluator should assess the results obtained from it, and any unplanned and unanticipated outcomes. Similarly, Argyris and Schon (1992) suggest that organizational learning occurs when reflection either affirms and strengthens current practices or causes a change of direction. The committee's effectiveness in encouraging organizational learning, more generally, must be assessed in terms of its ability to influence practices within the MHP overall. How well was the research committee able to influence practice and practitioners beyond its own membership?

The committee made no formal attempt to evaluate its own effectiveness in producing practice improvements. Yet, by June 1999, members agreed that in this arena the committee was hampered by its informality and lack of integration into management initiatives, program development and staff development. In section two I showed how, in

June 1999, the risk project had not yet achieved the aspiration of developing the routine and common utilization of methodically and rigorously generated information in the MHP. This remained a goal to be promoted by the development of the CIS, which, along with development of an MHP research agenda, would be the overarching strategy for ensuring that use of such information became more integral to practice.

Despite this, there were small, modest indications that services had been enhanced. "Quick and dirty" qualitative projects, initiated before the research committee was created, had affected MHP program practices. Similarly, committee projects had some successes in influencing services.

The qualitative study of Latino immigrants led to the successful development of group services in schools and to program expansion from one group for immigrants developed in 1994 to four such groups by 1996. These groups were discontinued in 1998, due to a reorganization in the local school districts that led to the closing of bilingual school programs. The resulting dispersal of the population more widely among many schools meant that school-based group services were no longer viable. However, the service was considered to be a successful technological innovation.

The PBR methodology had enhanced the assessment of individual clients and provided the group leader with a wealth of clinical information - *which she had organized into "themes" by virtue of a process of qualitative analysis done for research purposes.* This last analysis provided information that was used to develop a coherent structure for the group. From it also a methodology was devised, in the form of individual, personal narratives, that each participant created during the course of group meetings. In the fall of 1999 plans were underway to use this experience in the development of MHP services for Latino immigrants and for a group to address traumatization among refugees in this population.

The more quantitative loss survey, initiated in 1995, had proved to be an effective tool for program building. It helped the HIV Program gain wide visibility in several local schools and led to the MHP successfully developing several groups for HIV affected and HIV bereaved adolescents. It had also had an unintended positive consequence. It drew attention to the prevalence of unresolved losses for adolescents in the AC's communities of concern and to the disturbing finding that more than 75% of those surveyed worried about losses some, most, or all of the time. One outcome was the development of MHP group services to address this issue and the inclusion of questions about actual and anticipated losses in the AdQuest and team review.

The practice implications of two other committee projects - the clinical termination study and the exposure to violence study - were still emerging in the fall of 1999 as data analysis was being conducted. Nevertheless, the termination study had added momentum to the decision to develop a CIS and clarified that information regarding the way in which clients end services should be an element in the CIS related to, but separate from, treatment outcomes.

Bielawski and Epstein (1984) advise that effectiveness should be assessed in terms of the impact of an innovation on the pre-existing practice technology. Nevertheless, neither the report from Sidell's committee (Sidell et al., 1996) nor that from Turnbull's task-force (Turnbull et al., 1988) offers any discussion of this issue, though both claim that their efforts enhanced practice. Other articles (Pruet et al., 1991;

Subramian et al., 1994; Young, 1986) that describe attempts to integrate research into service settings do not address this as a measure of effectiveness.

Many interpretations may be offered in regard to why the impacts of these research development efforts on practice technology are not reported. One implicit reason might be that the field has been preoccupied with the cultural divide between research and practice, resulting in an emphasis on more preliminary issues, such as how to initiate research development or how to overcome practitioner "resistance " to it. Another factor might be that the subject is still too new, though this may seem odd considering that for more than thirty years schools of social work have been concerned about the research-practice divide. With little documentation in the literature of attempts to develop practitioners as researchers, more formative, exploratory questions have still to be answered. Perhaps practitioner led research activity does not produce results, in the form of technological changes, though it is unlikely that such activity has had no positive effect at all. Most likely, both practitioners and academics are setting too high a standard, a phenomenon that Epstein (1997, p 224) ascribes to the influence of the "gold standard" of experimental research. The fact that most proponents of research utilization in practice settings are academic researchers may also mean that more modest and preliminary discoveries are not considered by them to be rigorous enough to warrant implementation.

The experiences of the MHP, both before and after the research committee was created, suggest that academic researchers and practitioners alike have been too concerned with published reports on the impact of summative research studies implementation on practice effectiveness. The literature has focused on the impact of published findings on practice to the exclusion of the possible impact of small, modest, unpublished projects. A focus on published reports may lead to the conclusion that practitioners - whether they are direct service workers or management practitioners like myself - do not incorporate research findings into practice.

The experiences described in this dissertation suggest otherwise. In Chapter VI, I described how in the early nineteen-nineties the two small qualitative studies - practitioners' perceptions of client utilization patterns and practitioners' experiences with a short-term treatment model - led to innovations in the organization of the MHP. One result was the development of treatment review teams. Another was the development of group-based supervision models. Earlier in this chapter I described the impact that research committee projects had on program development during the late nineteen-nineties. These examples of practitioner utilization of PBR and its effect on practice may seem modest, incomplete and partial. Nevertheless, they suggest that practitioners may be more open to integrating research into practice than is often assumed to be the case.

The Research Committee and the Development of Reflective Practice and Organizational Learning

The effectiveness of the MHP research committee must also be considered in terms of the other aspirations that I had for it, particularly my assumption that it would be a vehicle that would use PBR to enhance reflective organizational learning processes. To assess the extent of the research committee's progress, I will consider internal committee processes and also the relationship between the committee and the MHP overall.

Many indications that reflective exchanges occurred between practitioners and managers within the committee can be seen throughout its development. Practitioners on the committee increasingly integrated programmatic perspectives when approaching practice problems and were able to utilize the PBR approach. The loss survey, the termination study and the risk project, are concrete examples of the application of programmatic perspectives to address an identified clinical issue. Despite the flaws in its implementation, the risk project showed that committee members embraced PBR and used it to develop rigorous ways to look at practice. It was the first research committee project to attempt this. The underlying concerns and insecurities of committee members, though present throughout the committee's first five years, only had a negative influence when it widened its field of interaction and approached other MHP practitioners to involve them in implementation. The committee was most effective in developing reflective processes within its immediate circle and less effective when dealing with the MHP overall. I conclude that this points to the problems, already described, regarding the formal definition of the committee's role within the MHP and its relationship to other MHP activities.

For most practitioners who participated in committee activities, the research-practice dialogue that resulted clearly filled a need. The committee generally maintained the motivation of its members despite their frustrations about its pace. It was less effective in creating exchanges with nonmembers, however, though it had strived to do this. Paradoxically, it might have generated more staff interest and participation than it did if it had focused solely on conducting projects within the MHP rather than trying to win the support of practitioners in other ways.

I have described how the evolution of the risk project showed that the committee was an effective vehicle for creating exchanges between research and practice perspectives between members, even if these processes ebbed and flowed. No evidence can be found that practitioners in the committee were unable to discuss openly their concerns about research or their lack of skills and, when the committee reevaluated itself, they were critical of how well it had supported their needs. They expressed feeling unsupported and exposed at times. The reader might wonder whether this issue could have been identified earlier, but the committee did not have a blueprint for development. It was engaged in multiple, intertwined processes that made it difficult, to identify and interpret underlying problems at the time they were occurring. The work of maintaining the committee's effectiveness as a vehicle for exchange and for a reflective process was, and is, ongoing and constant. The mere existence of the committee did not guarantee that these exchanges would occur. They emerged only when careful attention was paid to underlying concerns about research. However, without the committee these exchanges between research and practice would not have emerged at all.

How the meanings of these practice-research exchanges were interpreted as they were occurring was sometimes problematic and members' insecurities regarding their research skills may have distorted the interpretation of events.

For example, committee members' concerns regarding the negative effects of research on clients arose and were addressed. Yet in hindsight, at times they may have masked other unspoken questions regarding practitioner autonomy and standardization. When this happened during the program contact phase, the potential impact of the risk project on practitioners was not fully explored.

Generally the committee provided for an open exchange about many conflicts that emerged in the course of its work. Notably, tensions between administrators and practitioners - over resource allocation, control of the risk project, and over the time, rewards and support allocated to practitioners for their research activities - were voiced and addressed. In the summer of 1999 the committee was stronger than it had ever been because these conflicts were discussed and steps had been taken to address the underlying causes.

The MHP Research Committee Model: Efficiency

Efficiency was an important consideration in the initial development of the committee model and the selection of PBR as its methodology. The committee's creation of the "mentoring" model, in which members would foster research interest and activity among MHP practitioners as a group, was intended to provide mutual support for members and to be the most efficient way to use scarce resources. Efficiency was also one factor, among others, in the selection of PBR as a strategy. The PBR approach was chosen before Epstein was made available to the committee. Though he had been consulting to the Social Work Department since 1989, prior to my being hired, the research committee felt that he "matched" the PBR approach the committee had embraced "naturalistically," because of his expertise. However, PBR's appeal was also that, when it was compared with other research approaches, less practitioner time would be diverted from direct services due to its focus on integrating research into ongoing practice.

The committee was set up to make the maximum use of only twelve hours of consultant time annually. It decided that direct consultation to individual projects should occur in meetings of the whole committee. It proposed that committee members, when collaborating on a project with a group of colleagues outside of the committee, would serve as liaisons between the committee and the individual project. Thus, non-committee members' only had access to PBR consultation through the medium of the project leader and individual committee members would serve as informational conduits. Consultancy would be used to strengthen the whole group. Members were not naive about how much assistance each project might require but, aware of the scarcity of consultant time, they considered this group approach to be the most efficient use of this expertise.

Committee members were not sufficiently skilled to be able to mentor colleagues and the model created a disincentive for practitioners who were not committee members as they could not get direct access to expert help. In Chapter VI, I described how one "outside" group - working on a study of motivation for pregnancy in HIV positive adolescent females - came to resent the committee structure which resulted in the project's failure. The committee was unable to adapt its model at that time, largely due to the unwillingness of its practitioners to do so. One result was that committee members eventually had to conduct project work almost singlehandedly.

Ultimately, the committee's decision to focus on fostering practitioner interest throughout the MHP, while developing multiple projects, proved to be an inefficient strategy. Attempts to develop interest and participation outside the committee, were limited by several factors. One limitation resulted from the problems with the mentoring model, as I have described. Another resulted from the committee's informal relationship to other program subunits. Much of the committee's effort to communicate with other MHP subunits was informal, and its goal of generating enthusiasm for research, rather than focusing on research project development was unsuccessful. This contributed to the build-up of frustration among committee members during 1998. Together these factors meant that an estimated 50% of committee meeting time had been devoted to discussing issues that did not directly relate to projects. By June 1999 practitioners and committee co-leaders were convinced that efficiency would be improved only through a formal effort to better coordinate PBR work with other initiatives. I also decided that funds needed to be found and allocated to support increased consultant availability.

An Inefficient Committee Structure and Model: Limits on the Research Committee's Effectiveness

Committee members recognized that the research committee effort was not well aligned and coordinated with supervision, program administration, program development and staff development, which limited its efficacy. By the summer of 1999 practitioners in the committee wanted formal recognition of their work. This was requested by those who had worried that their status as "flagship members" might be compromised by the committee's expansion and its integration with supervisory and team structures. The desire to be more effective, and frustration that their work was not affecting practices more widely, outweighed this concern.

Managers and program coordinators also wanted formality in the form of accountability, evaluation of progress, and the integration of research efforts with programmatic agendas. The research committee had identified a requirement to adapt its approach to fit the changed environment. The new approach would require greater formalism overall and more resources and a research agenda to use as the benchmark to decide where practitioner effort and other resources should be spent.

Informality may have been the most effective strategy during the first two years of the research committee's existence, when it fit well with the informality of the AC. Given the lack of research activity and the apparent distrust of research among practitioners, it allowed exploration and exchanges about research to occur for the first time. This created a base for planning and led to the identification of opportunities for PBR. However, the MHP's administrative and supervisory structure became more formalized during the mid-nineteen-nineties, from the simple, informal, and intimate. In 1994 the social work supervisor and I embodied all administrative, supervisory and program development functions. In contrast, by 1998 staffing had tripled and new, specialized service areas had been developed. Administrative and supervisory functions were structured into an operational management group of ten senior staff, four interdisciplinary teams, and more decentralized supervision. As this had evolved the committee's structure and relationship to these subunits had not been reconsidered. The committee structure and its defined role were out of step with the level of formalism, coordination, and staff development that successful implementation of broad-based PBR projects would entail.

Practice-Based Research as a Strategy for Developing Reflective Practices

PBR was chosen as a methodology with which to approach research development among MHP practitioners early in the formation of the research committee. This choice evolved, not so much by a rational process in which the best model among alternatives was selected but, "naturalistically" in the way the committee approached its exploration of staff concerns and interests. During its first year the committee consisted of direct service and management practitioners and it had no PBR consultant. My committee co-chair and I were familiar with the PBR model through our doctoral course work and our initiation of modest qualitative research studies in the early nineteen-nineties. Epstein's availability, in 1995, added momentum to the committee's use of PBR that was already underway.

What made PBR the "natural" choice of the MHP committee? The committee had several concerns in its first year that suggested a good fit with PBR principles. (1) It was seeking to create opportunities for direct service staff to develop research skills by "doing." (2) Members hoped that by engaging in PBR, practitioners would learn to more clearly conceptualize and define their work and to enrich the clinical practice. (3) Committee members were research novices, and wanted a model with which they were comfortable. (4) Committee members believed that most MHP practitioners were research-aversive due to their lack of research exposure, their concerns that research would inappropriately impose changes on their practice, and their concerns that research might negatively affect clients. (5) They wanted practitioners to shape the research agenda.

How well did PBR serve the aspirations of the MHP research committee? As I have described, MHP practitioners within the research committee embraced the PBR model. Despite their feeling unsupported and unskilled at times, they were able to identify areas of interest relevant to their daily activities and to develop projects. The projects that arose were highly integrated with practice. The Latino immigrant project utilized assessment processes for qualitative interviewing and in so doing the research endeavor greatly enriched the clinical. The loss survey was a quantitative needs-assessment and program building tool. It helped build new services while simultaneously resulting in knowledge building and knowledge dissemination. I have already cited other examples of modest program enhancements resulting from the MHP PBR studies.

Earlier I described how PBR also appealed to the committee because participants were all extremely busy with their practice and it was thought that PBR would be the least intrusive, and most efficient approach. Projects had to be scraped together out of the busy life of the practice. Projects did develop, if very slowly, and most neared completion as my own study ended. Only one project - the study of the motivation for pregnancy in HIV positive adolescent females, involved a vain effort. The cumbersome committee structure was largely responsible for this, in that the project involved a group of practitioners whose affiliation with the committee was weak. As a result it was poorly coordinated and was even slower moving than those that were "in" the committee structure.

As I indicated earlier, participants were frustrated at times at the slow pace of the work, yet all have since expressed satisfaction as they complete their work. While credit should be given to PBR for helping practitioners, it cannot be held responsible for the committee's inefficient pace. I came to the realization that project work would remain slow-moving and extremely episodic unless practitioners were allowed more time to pursue it. Similarly, the committee decision to try to foster research participation among the whole MHP staff, which resulted in a misplaced effort at times, was not derived from PBR.

Evidence that the PBR approach enhanced reflective practice can be found in the impact of the MHP projects on the program. Practitioners came to integrate the practice context and program delivery issues when conceptualizing problems, when defining and conducting small projects, and when developing and implementing the risk project. The changing ways in which the challenges posed by the risk project were framed - from the design of clinical tools to the task of staff development and education - is a powerful example of this. My conclusion was that PBR was particularly suited to the aspirations that drove the MHP initiative but that it required more support in the form of increased supervision and training, and better coordination and management.

What strengths and limitations in the PBR model are suggested by the MHP experience? The PBR model seems particularly appropriate for settings where the work scope is overwhelmingly driven by practice concerns and where research may not be formally included in practitioners' job descriptions. However, though the PBR approach can be effectively integrated with the practice effort, it is not a cure-all for the problems that practitioners have in balancing research with other pressing service activities. I had underestimated just how much time and support the PBR effort would require. Nevertheless, the strength of the model when used in the MHP committee process was that it provided a vehicle for practitioners to identify and define these needs and make them heard.

The PBR model has other strengths suited to the current health care environment. Where pressures for high levels of service productivity might lead managers to be ambivalent about having practitioners engage in research activity, PBR offers a language and method that may be less threatening than "traditional" research models. First, the fact that it aspires to improve practice can be used by managers and practitioners alike to enhance its appeal to funders and other auspices. Managers can also claim PBR as a legitimate service activity as it can be defined as an evaluative activity or as quality assurance (QA) methodology. Second, because it can be integrated into supervisory and staff development activities - often seen as legitimate activities even in high volume services - it can help develop research activity without necessitating a great deal of visibility. As I have described, another benefit of the PBR approach has been largely unexplored in the literature. The MHP experience suggests that PBR, used in the development of modest practice studies, resulted in the integration of unpublished research findings into practice. This is in contrast to the concern expressed by many social work academics that findings from published studies are rarely integrated into practice.

The MHP Research Committee as a Vehicle for Developing Reflective Leadership

The research committee's effectiveness as a vehicle for creating reflective organizational practices can also be assessed in terms of the opportunities it created for exchanges between other MHP staff and me as the MHP Director. Managerial decision making is not a highly rational process as managers make decisions with partial, imperfect information (Patti, 1978; Morgan, 1980, chap. 4). Decisions must often be made quickly as issues emerge, and decision-making will depend on how issues are framed (Argyris & Schon, 1992). Therefore, managers' access to information is subject to many constraints, including lack of adequate time to explore issues and the varying criteria that different subsystems and individuals apply when determining what information is relevant or can be shared.

The committee was effective in allowing me access to perspectives and viewpoints about practice that I might not otherwise have had. It gave me a direct view of practice issues without their being filtered through a hierarchical administrative system or through the problem-focused, case-centered lens of clinical supervision. The nature of this reflective process differed from my everyday management decision-making. Just as practitioners developed a more programmatic lens through which to view practice, so I developed a view of the program influenced by their concerns. I was able to clarify many unspoken challenges that the practice environment presented to practitioners. In particular the research committee served as a vehicle to allow me to explore informal organizational factors - such as the function of ambiguity in assessment practices - that allowed practitioners to engage adolescents effectively.

In addition, my committee participation afforded me a window into the "unwritten," implicit demands that the MHP practice environment made on practitioners. When they asked for greater clarity about expectations of research participation, I became aware of the potential benefits of clarifying the core competencies expected of AC social workers regarding all aspects of their work. As a result, formal competency standards were developed by two practitioners and me during the fall of 1999 and are presently being integrated into the AC performance appraisal process. Currently, they are being circulated among other Medical Center social work managers as an exemplar of one way in which performance-appraisal processes can be enhanced by having practitioners participate in developing an iteration of the complex skills required in their everyday work, so that performance-appraisal is conducted in the context of the full scope of the agency's activities.

As I reflected on the highly informal nature of practice - the valuing of practice over protocol - I also became aware of the difficulties that the practice environment and organizational culture presented for newly hired staff. I set about to develop orientation materials and initial performance appraisal guidelines that embodied key practices to aid in the recruitment, orientation and evaluation of new staff.

The most significant new understanding that I obtained concerned the need for balance between informality and formalism in the organizational system and the functions that each of these qualities played in achieving organizational goals. As I reflected on the research committee experience and the risk project development, I developed a deeper appreciation of the intricate balance that MHP practitioners had to maintain between engaging the trust of their adolescent clients and appropriately responding to their needs. I will describe this powerful insight that resulted from my participation in the research committee and the risk project, shortly, but first I will discuss some possible benefits and hazards of formalism in the research effort.

5. Implications: Contextual Factors in the Selection of Formal Versus Informal Approaches to Developing Practitioner Research

The risk project had identified the need for more formal and structured relationships within the research committee and between it and other MHP activities. Without a more formal role for the committee in the activities of the MHP, practitioners would not routinely and uniformly integrate clinical information derived by PBR methodology into their everyday activity.

For the MHP and for other social welfare and health care organizations in which research has not been an integral component of the organizational effort, or where resources must be carefully accounted for, a highly formal research effort presents benefits and risks. Many benefits now seem evident, though they were not evident to me during the development of the MHP research committee. An organizational research agenda can provide a blueprint with which to coordinate research efforts with other initiatives. This can help ensure efficiency, particularly in helping determine how to use limited resources. A research agenda linked to the programmatic agenda can help determine where effort should be expended - particularly when one cost to agencies takes the form of practitioner time being diverted from direct practice activities. This lesson may apply to other social welfare organizations with limited resources and high service levels.

A formalized committee structure has other benefits. Informality in approaching research development may be appropriate in settings where practitioners are very wary of research or where research activity might be met with disapproval from funders or other auspices. Where staff are participating in PBR, formally recognizing this in the performance-appraisal process, and having a clear and formal iteration of the agency's expectations and rewards, can help ease the anxieties associated with this activity.

Having formalized expectations regarding staff research participation can make research activities more visible than a more informal support effort might do and should be chosen only where minimal conflict with the organizational mission and funding mandates might result. However, even in settings that are hostile to allowing practitioners to engage in research, merging PBR activities with quality assurance or other evaluation initiatives might be one strategy to avoid censure. Having a clear and formal iteration of the research plan can also provide social work managers a framework with which to justify the research effort - in terms of service improvement, program and funding development, and QA. The experience of Sidell et al. (1996), described earlier in this Chapter, provides one exemplar of how a clear research strategy linked to unmet service needs can result in increased institutional support.

6. Implications: The Role of Idiosyncracy and Ambiguity in Mental Health Practice with Adolescents - Why Practitioners Might "Resist" Standardization

My colleagues and I had concluded that the MHP research effort should be formalized through a planning process and through coordination between the research committee and other program development, administrative and staff development efforts. It would take a concerted effort to achieve a working environment in which information played a more common and formative role in practice decisions. Yet, as I contemplated this undertaking, I gained an insight into the complex dynamic between formalism and informality, about the search for clarity and the need for ambiguity, in mental health practice with adolescents, and about the problems of standardization of assessment practices.

The implementation of the risk project had drawn my attention to the informality of the organizational culture of the MHP - specifically in the engagement of clients. This aspect of the organizational culture had been revealed often during the design and implementation of the AdQuest. The committee had viewed the MHP's informality in the client contracting process as resulting from supervisory inattention, and they had assumed that if more consideration were to be given to these areas of practice the development of more formalized protocols for discussing confidentiality and consent to treatment would be an outcome. They saw this as an unequivocal service enhancement.

When the committee first considered the implications of the MHP's highly informal, variable and seemingly idiosyncratic contracting processes, committee members explained this variance in terms of practitioners' preferences, ideologies and styles.

Because awareness of these inconsistent practices had helped define the purpose of the risk project, and had shaped the AdQuest, committee members had been excited by the idea that their PBR work could help identify other inconsistencies in service approach. Their perspective - that informal contracting procedures and an apparent aversion to standardization were the result of inattention - led to the neglect of other interpretations as to the causes and meaning of this phenomenon. Though it was true that a concerted and rigorous effort to examine contracting processes had not been undertaken, no consideration was given to the possibility that there might be some functional value attached to apparent variation in contracting practices during the assessment phase of treatment. I too had viewed this phenomenon as an ideologically-based outgrowth of practitioners' preferences for autonomy in clinical decision-making and I had assumed it to be an impediment to progress in implementing the risk project.

The research committee self-evaluation brought the issue of standardization, formalism and informality into a sharper focus. In the spring of 1999, as my colleagues and I reconsidered the committee's structure and methodology, I interpreted the committee's informal and incremental approach to be the result of three factors. First, I thought that it fit with, and reflected, many aspects of the informal organizational culture. This was also the view of most research committee members. Second, I thought that the committee had grown out of step with the evolving MHP, and that its informality simply no longer fit. The third factor that I considered to have contributed to the informality of the committee style related to the historical divide between research and practice and to practitioners' antipathy to research. Although committee members had embraced PBR, I believe that lingering uncertainties about research and insecurities about a lack of expertise contributed to a preference among members for informal approaches to research development. Throughout the committee's development members had been preoccupied with their own lack of research skills and with potential practitioner resistence to research.

While each of these interpretations offers insight into the committee process, they overlook ways in which informality may have contributed to engagement. As the CIS was being considered, between November 1999 and January 2000, I talked with many practitioners at length about their use of the AdQuest during the assessment process and this was discussed extensively within the CIS workgroup that had formed during that time. I will summarize what I learned about the emerging uses of the risk project instruments.

By the end of 1999, practitioners were using the AdQuest quite routinely, and not only in difficult cases. Though there were variations between individual practitioners as to when they discussed the AdQuest with clients, these variations did not seem to be related to the plan each team had made for implementation. This is not surprising given the lack of monitoring at the team level. It appeared that the AdQuest was now being discussed routinely with more than half of the adolescents assessed, and many practitioners were settling more into routine use of the instruments. Though there was variation between practitioners as to how and when they discussed the AdQuest with their clients, they showed more consistency in their individual patterns of use, in contrast to the implementation pilot when each individual practitioner used the AdQuest differentially with each case. Two patterns seemed evident. Some practitioners scanned the AdQuest before their first interview and briefly discussed any anomalies between it and information that arose in the interview, returning to it at some later point in the three session intake process. Others discussed it only during the third and final interview after their fact-finding was completed and they were discussing the treatment plan with clients. The teams were also gradually beginning to use the clinical information obtained from the instruments. One of the psychiatrists and one team leader, each involved in different teams, was reviewing the completed AdQuest during the practitioners' presentations of completed assessments.

Finding less resistance to the AdQuest than I had anticipated, I was impressed by the way that some practitioners were exploring its use, without any direct supervisory pressure or monitoring. It appeared that the decision to have a loose and exploratory approach to implementation was showing signs of subtle and gradual success. I concluded that the informality and resistance to standardization in the assessment process might not simply result from idiosyncratic practitioners and weak formal protocols, but might serve an essential engagement function.

The literature on the introduction of monitoring, effects management, and evaluation and research methodologies in practice has focused on overcoming practitioner resistance and distrust (Bloom, Fischer & Orme, 1995; Grasso, 1986; Grasso & Epstein, 1987; Rubin & Babbie, 1989; Savaya & Spiro, 1997; Savaya, 1996; Tripodi & Epstein, 1980; Weinbach, 1985; Weissman, 1983). Many of these writers are academicians and/or researchers. Even those among them who identify strongly with practice, explanations as to why practitioners appear to resist research have focused on differences in viewpoints, values and ideologies between researcher and practitioner. The idea that one cause of practitioner resistance to evaluation methodologies might be that it threatens necessary engagement functions has not been adequately explored. As a reflective management practitioner my own perspective was very different. How could I understand whether seemingly non-rational, informal practices should be preserved, even as I initiated a more formal approach to PBR development?

Garfinkel's (1967) ethnomethodological approach, which was developed to investigate "the routine grounds of everyday activities" (p. 35) to understand "common culture," provides a frame which to approach the problem that I faced. Common culture, by Garfinkel's definition is the "socially sanctioned grounds of inference and action that people use in their everyday affairs" (p. 76). His studies include jurors' decision making processes, the "informal" criteria used to decide which applicants for services were admitted at a psychiatric outpatient service, and the function of the service records in mental health services. Garfinkel shows the utility of investigating the normal routines and informal rules to reveal an underlying common-sense social structure behind everyday behaviors that is constructed to suit a functional social purpose. Garfinkel poses the question "What kinds of expectancies make up a 'seen but unnoticed' background of common understandings and how are they related to persons' recognition of stable courses on interpersonal transactions" (p. 44)?

In his paper, "good organizational reasons for bad clinic records," Garfinkel (1967, p.186) considers why mental health clinic records are invariably inconsistent and inadequate from the point of view of an outside investigator examining documentation, the "facts" about each patient and the patient's "clinic career." These facts, that Garfinkel calls the "actuarial" (p. 197) aspect of the record, might include information regarding each patient's characteristics, use of services, motivation, termination pattern, and so on, as well as the interventions made and services rendered by the practitioner and agency. Garfinkel suggests that:

> [Because] . . . "bad records" . . . [are such a common problem and] . . . hospital and clinic administrators frequently are knowledgeable and concerned about these 'shortcomings' . . . the sheer frequency of bad records and the uniform way in which they are 'bad' [suggests that the] . . . great uniformity of 'bad records' is a sociological phenomenon in its own right (1967, p. 191).

To understand this phenomenon Garfinkel (1967) draws distinctions between the actuarial and contractual uses of records. The contractual function of records is to "define normal relationship" (p. 199) by serving as the "unformulated terms of a potential therapeutic contract" between the patient and the practitioner. The record portrays this relationship in accord with the "expectations of sanctionable performance by clinicians and patients." That is, the record presupposes a shared understanding of its meaning, and an order for its correct reading and interpretation by others. The contractual function is not to offer an account of what may have happened at a point in time in the encounter between practitioner and client but to frame the nature of what is proposed as the continuing therapeutic endeavor. It anticipates the future, rather than documents the past, even though its terminology and content appear, superficially, to be actuarial. The client record contains the implicit, proposed therapeutic contract and it evolves, as the definition of the proposed and anticipated therapeutic changes from contact to contact. All other functions of the record are subordinated to this contractual function. Garfinkel concludes that:

> When the case folder was read as an actuarial record its contents fell so far short of adequacy as to leave us puzzled as to why 'poor records' as poor as these could be so assiduously kept. On the other hand, when folder documents were regarded as unformulated terms of a potential therapeutic contract, i.e., as documents assembled in the folder in open anticipation of some occasion when the terms of the therapeutic contract might have to be formulated from them, the assiduousness with which folders were kept, even though their contents were extremely uneven in quantity and quality, began to 'make sense' (1967, p. 200).

Applying this approach to the MHP assessment and intake process, I was reminded of the canonical values encoded in official AC documents. In particular I considered the paradox between official views of clients. On the one hand they are defined as "responsible consumers of services" - a value encoded in the service's mission statement. And yet, they are frequently referred to as a high risk population, by virtue of risky behaviors and attitudes - a description also encoded in many of the AC's official service descriptions. These conflicting values could be seen in many aspects of organizational life, from written documents to case presentations. The organizational culture contains very mixed messages about how clients are viewed and different inferences might be drawn as to how adolescents should be treated. How much autonomy over decisions should they be given? How might these paradoxical messages affect practitioners?

That client risk factors preoccupied and worried practitioners cannot be doubted as these worries had been one impetus behind the formation of the risk project. Paradoxically, practitioners had to engage adolescents by developing a relationship within which clients could trust practitioners. To work, this relationship must - to a great extent - "contain" and tolerate the client's inconsistencies, experimentation, and mistakes. Adolescent clients were "officially" dealt with as responsible adults and allowed the same parameters of confidentiality, with only most egregious risk factors leading to a clinician "breaking" confidentiality. Yet, Mirabito's (1997) study of the MHP and my own (Peake, 1991), had shown that practitioners had to "contain" a great deal of concern and anxiety about clients. To maintain confidentiality, practitioners routinely "lived with," and "kept to themselves," the knowledge of their clients' risk behaviors. As they negotiated a maze of difficult issues in their daily work, clients told them about their risk behaviors, disclosures of which to a parent would effectively cripple the MHP's ability to engage high risk young people.

MHP practice guidelines were largely unwritten and communicated by example, more often through informal mentoring than formal consultation. The highly informal, seemingly ambiguous, "unstandardized" practices and systems, all show how much practice took precedent over protocol. Yet, the informal and unwritten nature of contracting, and of practices regarding parental notification and involvement, parental consent, and patient confidentiality, might allow practitioners the room and flexibility that they needed to balance the stressful and complex task of balancing engagement and risk assessment.

Engagement of adolescents involved the creation of a confidential space in which clients could safely discuss their behaviors. Risk assessment required that practitioners were able to establish a trusting relationship and also respond appropriately to factors that endangered clients. How much specificity about clients' attitudes and behaviors could be recorded in questionnaires and service records? Would doing so leave individual practitioners exposed and at risk for their tolerance of risky behaviors? Practitioners might effectively practice while "containing" their doubts and concerns about clients, but would feel exposed if these doubts and concerns were codified in the formal record or subject to formal, rule-bound protocols and official procedures. Although MHP service records provide ample evidence that many risk behaviors were documented, though inconsistently, the lack of standardization and routinization might be a reflection that the practitioner might need to know that she alone should decide what was recorded, when it was recorded, and in what context. Whereas, practitioners might know more about the client than was officially acknowledged in the case record, more standardized documentation of each individual client's actual risks and behaviors might threaten the practitioner's room to maneuver. It might leave him or her exposed if, in the event of some later, unfortunate circumstance, it appeared that risks had been "ignored."

Garfinkel (1967) has termed this type of strategy for coping with contradictory social expectations "ad-hocing" (p. 30). Applied to the MHP it would require that practitioners be highly familiar with the official, "expected" norms and codes and act so as to appear compliant with them. Yet, they might need to simultaneously and temporarily disregard those "protocols" and rules that conflicted with the practical, informal everyday tasks required to engage the client.

As I explored this issue with practitioners, I received affirmation from them. One very experienced practitioner commented that if he thought about the thousand risks affecting the adolescents that passed through the service every day he could not function. The metaphors of adolescent responsibility, autonomy, and the right to confidential services, and the overwhelming concern about the "protection" of the client that runs through this narrative seem inseparable from the metaphor of practitioner autonomy.

What are the implications of this interpretation for the MHP? How does the CIS workgroup proceed without compromising the ability of MHP practitioners to work effectively? How much culture change will be required and what aspects of the culture should be carefully preserved?

When the research committee was established, it did not view itself as creating a culture change, and in 1995 its goal of enhancing practice and developing research interest, skills and activities within the MHP staff seemed synchronous with the MHP's micro-organizational culture and the wider organizational culture of the Medical Center. The committee had aspired to help practitioners more closely fit with the official values of the Social Work Department. The risk project had paradoxically embodied qualities of the organizational culture's ideal of the knowledge-hungry, ever learning practitioner and "exposed" aspects of the MHP culture that seemed to run counter to those values. The issue of culture and possible culture change had not been discussed in any depth within the research committee and only emerged as I began to discuss this case study and my observations at the end of 1999.

How likely is it that the MHP practitioners will be able to adapt and become users of PBR derived clinical information? While the functional aspects of practitioner-autonomy might seem to mitigate against the development of more formal protocols, there are potential benefits that the PBR approach - as applied to exploration of risk factors - might provide. Developing more sensitive measures of client risks might help practitioners live more comfortably with their clinical decisions. Developing the capacity for practitioners to compare their everyday experiences, and creating opportunities for exchange about the practice dilemmas that arise in working with clients might relieve their burden.

Looking to the future it appears likely that if the informality of the organizational culture has an important and useful function some aspects of it should be maintained and protected. The CIS effort will need to involve careful consideration as to where in the practice collection of standardized information is best done and what impact this might have on practitioners' room to maneuver. Most importantly, this is the work now being undertaken within the CIS workgroup. Consideration of the "treatment culture," offers hope that essential, functional aspects of the "informal" practice can be iterated and maintained even as greater rigor, standardization and clarity, regarding assessment practices is pursued.

7. Conclusions and Implications for the Field: New Pathways in the Investigation of PBR Methodology and Practitioners' Use of Research-Derived Knowledge

This dissertation offers a management practitioner's view of a collaborative effort to develop PBR within a mental health service for adolescents. The collaboration was a partnership between direct practitioners and managers that evolved over a seven-year period. The experience was a unique one, both in terms of the setting and the period in which the innovations were developed. As the investigator my own role was that of a highly partial, highly invested participant. My colleagues and collaborators were also a unique group, each having his or her own perspective and practice approach shaped by individual experience.

The MHP setting has many unique qualities. Its diverse funding has meant that practice is not constrained by managed care and that services are not rationed. Practitioners and program alike are limited mainly by clients' utilization patterns and by the limits of existing practice knowledge. The agency's commitment to confidential services, and the array of services it provides, seems highly unusual if not unique.

The study methodology was also unusual and there are hazards in applying the lessons learned from the AC experience to the field overall. I am aware of the dangers of generalizing from this experience. Yet, having given that proviso, I will attempt to identify possible implications that this study may have for other practitioners and researchers.

The participant observer methodology and the unique characteristics that shaped this case study also give it potency. This study offers a view from the ground, from a busy, pressured service setting. In the seven years covered in this narrative, MHP practitioners had more than a hundred and twenty thousand encounters with clients, and assessed and engaged many hundreds of adolescents. Thus, my perspective is that of a management practitioner engaged in the chaotic, everyday world of practice. This organizational case study is in the tradition of clinical case studies and case presentations that are the *lingua franca* of practice. As I discovered when I sought published descriptions of similar group efforts to develop research among practitioners, too few case studies have been documented.

The narrative offered here evinces not only the struggles, successes, and failures of a manager's daily life over a seven-year period, it describes the efforts of a group of direct practitioners to enhance their practice and their agency. Our efforts are described, "warts and all," and the reader will identify issues and themes, successes and failures, that my colleagues and I overlooked. When this occurs it will be a sign of the success of this study, as my goal was not to write a definitive manual for developing reflective organizational practices but *to provide an exemplar so that others might relate to and learn from, through its imperfections.*

Mindful that different readers might draw fresh and novel lessons from this account, I offer observations regarding the implications that this study has for the research-practice exchange in relation to two areas of practice knowledge. First, I describe why this case study suggests a new pathway for exploration of evaluation and research methodology in practice settings. Second, I will describe what this study may suggest about the investigation of practitioners use of research-derived knowledge.

Practitioners have often been described as research-aversive and as failing to appreciate the relevance that research-derived knowledge has to our practice. Academic social workers have offered many explanations for the tense dichotomy between research and practice. These range from the implication that practice is ineffective and that practitioners fear exposure (exemplified in Bloome et al., 1995), to the view that research and practice have different concerns and values (Adler et al., 1993; Pruett et al., 1991; Sidell et al., 1996). Research is seen as a science and practice as an art (DeRoos, 1990; Goldstein, E., 1979; Goldstein, H., 1986; 1993; Siporin, 1988). PBR, the method utilized in the development of the MHP research committee, has offered a vehicle to bridge some aspects of this divide (Epstein, 1995; 1997; Sidell et al., 1996).

The literature that describes the introduction of evaluative methodology and monitoring tools into practice represents these diverse views. Some (Bloome, Fischer & Orme, 1995; Blythe & Briar, 1984; Blythe, Tripodi & Briar, 1994), suggesting that practice should be more "scientific," have argued for research-based practice. They have suggested that practitioners should use methodologies that lend themselves more easily to quantification of goals, interventions, or outcomes. One result is that, in the words of Wakefield and Kirk (1996) "they attempt not just to improve the knowledge base of practice, but also to transform social work practice itself into a form of scientific research" (p. 83).

There are other "empirically oriented" practitioners who follow in the tradition of Thomas, (1984) who says: "research methods do not replace practice procedures; rather they augment and provide empirical grounding for the information dealt with in practice. Again, the ultimate objective is service not research" (p. 254). PBR has offered an alternative "practice-friendly" paradigm that aspires to use research methods to enhance practice and offers research approaches that do not, explicitly require that practitioners change their practice methodologies.

Yet, even writers who are sensitive to the nature of interpersonal practice have continued to focus on the differences in *orientation* between practitioners, managers and researchers, to describe the problems of integrating research methodology and knowledge into practice. Invariably, they have focused on theories about attitudinal factors to explain practitioner resistance. These include theories regarding values, ideologies, orientations, viewpoints, and aversions or fears. Some (Subramian et al., 1994, Pruett et al., 1991, Simon, 1991, Young, 1986) have identified practitioners' *lack of skills and familiarity* with research derived approaches. Grasso and Epstein (1987) have highlighted the *ideological* basis for differences and conflicts between managers and practitioners as a factor in practitioners' distrust of evaluation methodology. Some describe practitioners as thinking of research as cold and impersonal in contrast to interpersonal practice which is warm and intuitive (Ruben and Babbie, 1989). Others have focused on *"practitioner viewpoint"* - that is the task-focused, instrumental orientation that practitioners use in approaching practice problems - and its conflict with evaluation methodology (Sidell et al., 1996). Savaya and Spiro (1997) focus on practitioners' *fears* that monitoring and effectiveness measures will undermine their professional autonomy.

Yet, none have investigated the microcosm of clinical interactions in interpersonal practice so as to understand how standardization and formalism might concretely affect everyday engagement. Do such initiatives threaten seemingly idiosyncratic but necessary practices, by upsetting the everyday, unwritten and functional aspects of practitioner autonomy. So far PBR has stopped short of investigating "practitioner autonomy" in terms of its function in engagement and how evaluation methodology actually affects this process.

My analysis of the dynamic between formalism and informality in practice, and between standardization and practitioner autonomy, builds on the work of PBR, but it suggests that investigation should go further to explore the practical and common problems of integrating research methods into practice from the perspective of everyday, "informal" but necessary interactions - a true practice perspective.

Guided by Garfinkel's (1964) phenomenological approach, I have offered a preliminary perspective regarding the function of idiosyncratic practices, informality and practitioner autonomy. Given that so little is understood about the phenomenology of this aspect of practice, reflective, participant observer methods, and case studies such as this, have much to offer. Though the MHP example is limited to practice with adolescents, and particularly to engaging and contracting, other studies might be used to identify similar practice issues encountered by practitioners working with other populations.

A second implication of this "naturalistic" case study is what it suggests about practitioners' willingness to integrate research findings into their practice. Perhaps because the literature has primarily offered the perspectives of academics, it has focused on practitioners' failure to integrate findings from published studies into their practice. The MHP experience suggests that practitioners - when supported with consultation and a group process - might be willing to integrate the lessons learned from PBR into practice, despite their feeling exposed as a result of being unskilled in research. Once projects were initiated within the MHP research committee, the discoveries were embraced eagerly by practitioner members.

This retrospective case study offers many examples in which small, "soft," unpublished, research studies - developed by practitioners - affected program and practice. This included the development of supervisory models, assessment teams, new services and assessment instruments. These are modest examples implemented in one small program, but over the years they may have affected the lives of thousands of adolescent clients. Although one must be careful as to the conclusions drawn about the overall applicability of the MHP experience, it does suggest that further study be made of the occurrence of "research-like" projects in practice settings and the utilization of non-published findings. Furthermore, the reflective, participant-observer methodology can play an important role in such investigations and in creating a wider array of organizational case histories than are currently available.

Appendix A: Agency Sources Referenced in the Text

1. Adolescent Center Advisory Board Commencement Report, Fall 1999
2. Adolescent Center Business Plan, November 1999
3. Adolescent Center Community Services Inventory, Fall 1994
4. Adolescent Center Community Youth Program Annual Report to Funder, September 1997
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7. Adolescent Center Mental Health Program Research Committee Mission Statement, Summer 1999
8. Adolescent Center Mission Statement, June 1998
9. Adolescent Center Mission Statement, April 1994
10. Adolescent Center Program Description, April 1994
11. Adolescent Center Program Description, January 1992
12. Adolescent Center Program Description, June 1998
13. Adolescent Center Program Description, October 1999
14. Adolescent Center Program Description, October 1999
15. Adolescent Center Research Unit Strategic Plan, Draft Fall 1999
16. Adolescent Center Strategic Plan, Draft December 1992
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20. Adolescent Center Vision Statement and Preliminary Business Plan, June 1998
21. The Challenges of Serving Adolescents, Pamphlet, Division of Adolescent Medicine, January 1996
22. Department of Community Relations, Community Service Plan 1995
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28. Division of Adolescent Medicine, Adolescent Medicine Fellowship Training Program Accreditation Application, June 1999
29. Division of Adolescent Medicine, Description, April 1995
30. Division Chief, Adolescent Medicine, Chairman's Statement July 1998
31. Medical Center Annual Report 1998
32. Medical Center Annual Report 1999

APPENDIX B: An Initial Draft for Items to Include on an Adolescent Risk Inventory Questionnaire - January 1997

This document was an inventory of questions developed by the MHP research committee in its first "outline" for an adolescent questionnaire, in January 1997. Within two months, this crude draft - which was in inventory form - was to evolve into the AdQuest, a final version of which can be found in Appendix C .

The "questions" were sorted into rough categories. All were planned to have closed-end "yes"/ "no,"except_unless marked with an asterisk, in which case the question was planned to be open ended. This inventory was not a completed instrument and was never administered.

* open-ended questions

Motivation for Treatment:

Please tell us why n you are looking to start counseling now?
What do you hope to get out of it?
What are three things that concern you the most?
Who should we contact in case of an emergency?
    Relationship?
    Address?
    Telephone#?

Safety /Violence

Have you ever had to carry a weapon?
Do you have easy access to a gun?
Is there a gun kept in your home?
Have you ever witnessed violence/a violent act?
Ever been a victim of violence?
Have you ever been threatened with a weapon?
Have you ever been in a physical fight?
Have you ever been forced to have sex?
Do you and your boyfriend/girlfriend ever physically fight?
Have you ever had any legal problems?
Has your girlfriend/boyfriend ever hit you?
Have you ever been a member of a gang?

Sensation Seeking Behaviors

Have you ever tried riding between two train cars?
Have you ever tried elevator surfing?(riding on top of elevators)?
Do you ride your bicycle against traffic?

Have you ever tried "Skitching" (hitching a ride on the rear/back of the bus with your skates/roller blades)?
Do you ever feel the urge to cross the street when traffic is approaching?

HEALTH

Personal health

Do you have any medical problems or concerns?
Do you like your body?
Do you worry that you are overweight or underweight?
Do you ever make yourself vomit?
Do you take laxatives or diet pills to loose weight?
Do you ever try to go a whole day or days without eating?

Sexual Health

Have you ever been taught how to correctly use a condom?
(Aids/Sex Ed)
Have you ever had sex
How old where you when you first had sex?
If you have ever had sex, have you or your partner ever used birth control?
  * Develop questions to explore number of lifetime sexual partners, birth control & risk reduction behaviors, age of partners.
Have you ever had a GYN exam or your genital area examined by a doctor?
Have you ever had an abnormal Pap Smear?
Have you ever had a sexually transmitted disease
  VD (gonorrhea, chlamydia, syphillis, herpes, genital warts,

AIDS, HIV

Have you ever thought about testing for HIV/AIDS?
Have you ever been tested for HIV/AIDS?
Have you ever been taught about how to prevent HIV/AIDS infection?

Sexuality

Have you ever been pregnant or gotten someone pregnant?
How would you describe yourself? (Circle below)
  Heterosexual
  Gay
  Lesbian
  Bi Sexual
  Transgender
  Don't Know

Have you ever been attracted to someone of the same sex as you?
Have you ever been worried about your attraction to persons of the same sex as you?

Have you ever used drugs or alcohol in order to make sex easier, longer, or more fun?
Have you ever exchanged sexual activity or contact for money, drugs, food, or shelter?
Do you ever worry about any issues concerning sex?
Do you have any questions or concerns about sex, your body, or birth control?
In your opinion, do you think you will need to talk about any of the above issues with your counselor?

Drugs and Alcohol
Has anyone ever offered you any drugs?
Do you know someone whose drug or alcohol use worries you?
Have you ever felt alcohol or drug use is a problem for you?
Have you ever worried about your use of alcohol or drugs?
Have you ever tried to cut down?
Have you ever felt guilty about your substance use?
Do you know anyone who uses drugs or alcohol?
Do you hang out with anyone who uses drugs or alcohol
Have you ever tried any of the following?
    Tobacco (cigarettes, snuff, chew)
    Alcohol (beer, wine, wine coolers, hard liquor)
    Marijuana (pot, weed, reefer, boom, chronic, blunts, joints)
    Crack
    Cocaine (coke, snow, blow, free base)
    Hallucinogens (ecstacy, special K, LSD, acid, angel dust, mescaline, mushrooms, PCP)
    Inhalants (glues, poppers)
    Heroin (white lady, smack)
    Pills (uppers,downers)
    Steroids
    Laxatives
    Others

Psychiatric History
Circle any of the feelings below which might describe you:
    depressed
    lonely
    sad
    nervous
    angry
    isolated
    hopeless
    frustrated

Have you ever worried about hurting yourself or someone else in any way?
Are you having any problems at home?

Have you ever been in foster care?
Have you ever had counseling before?
Has anyone in your family had a problem with drugs or alcohol?
Has anyone ever touched your body in a way that was uncomfortable or without your consent?
Have you ever had thoughts of having sex with someone against their will?
Do you carry a weapon?
Have you ever had to use a weapon before?
Have you ever done something that you knew was against the law/ committed a crime?
Have you ever been arrested?
Have you ever been convicted of a crime?
Have you ever physically hurt someone else?
Have you ever thought about committing suicide(killing yourself)?
Have you ever thought of a plan on how you would attempt suicide?
Have you ever tried to commit suicide?
Have you ever thought of ways of hurting yourself?
Have you ever cut yourself or made marks on your body?
Have you ever gone to the hospital for the reasons just asked?

Family Medical History:
Does anyone in your family have:
  diabetes?
  high blood pressure?
  asthma?
  heart attack or stroke?
  TB(tuberculosis)?
  cancer?
  AIDS/ HIV+?
  Sickle Cell?
  Psychiatric problems?
  Drug Abuse?
  Alcohol Abuse?

APPENDIX C: The AdQuest

ALL ABOUT YOU!

The following questions are about you, your opinions, and issues that affect teenagers and young adults.

Your answers will be reviewed privately, between you and your counselor today.

Please answer as many questions as you can so that we can be sure we understand you and how to best help you. Your answers will help us to provide the best possible services to you and other young people.

If you have any questions about anything below, your counselor will be glad to talk with you.

If you need help or don't understand any of the questions
please ask us

INTAKE WORKER: **TEAM:** **DATE:** **#**

ALL ABOUT YOU

The first questions ask you some personal information to help us understand you better

1. **Your Name:** ______________________________

2. Your Date of Birth: ____________

3. How old are you? (Please circle one)

10 11 12 13 14 15 16 17 18 19 20 21

4. What sex are you? Male ___ Female ___

5. What is your race or ethnicity?

___ African American

___ Asian or Pacific Islander

___ Hispanic / Latino

___ Other (Please write in) ______________________________

___ West Indian/ Caribbean

___ White (non-Hispanic)

___ Don't know

6. Are you proud of your race and ethnicity? Yes___ No___ Don't Know___

7. Have you ever experienced racism? Yes___ No___

8. What Religion are you? (Please write in) ______________________________

9. How much do you want to talk to your counselor here about any issue with your race or ethnicity?

1	2	3	
Not At All	Somewhat	Very Much	Don't Know ____

SCHOOL AND WORK

The next questions ask about school and work. Education and work are important parts of every young person's life. We are interested in your needs, opinions, and experiences.

10. Are you in school? **Yes ___** **No___**

If NO, please skip to question 15

11. If you are in school or college, what grade are you in? ______ **Don't Know___**

12. Are you failing any classes? **Yes___ No___** **Don't Know___**

13. How do you rate the school you attend?

1	2	3	4	5
Very Bad	Bad	Average	Good	Very Good

14. Which of the following describes your school attendance best?

1	2	3
I often miss classes	I sometimes miss classes	I almost never miss classes

15. Do friends or family members worry about how you are doing in school or with your education? **Yes___ No___** **Don't Know___**

16. In general how are you doing with your education?

1	2	3	4	5
Very Poor	Poor	Average	Well	Very well

17. How much do you want to talk to your counselor here about any school or education issues?

1	2	3	
Not At All	Somewhat	Very Much	Don't Know _____

18. Are you currently working? Yes___ No___

If No, please skip to question 21

19. Do you have any problems on the job? Yes ___ No___

20. Do you have any problems balancing work and other responsibilities? Yes ___ No___

21. If you are not working, do you want to work? Yes ___ No___ Don't Know___

22. How much do you want to talk to your counselor here about any work or employment issues?

1	2	3	
Not At All	Somewhat	Very	Don't Know ____

YOUR SAFETY

Many young people have concerns about their own personal safety

The following questions are about your experiences

23. Have you ever witnessed violence? Yes___ No ___

24. Do you ever feel unsafe? Yes___ No ___

25. Have you ever been threatened with a weapon? Yes___ No___

26. Have you ever been a victim of violence? Yes ___ No___ Don't Know___

27. Has anyone ever touched your body in a way that made you feel uncomfortable? Yes___ No___ Don't Know___

28. Do you and your boyfriend / girlfriend ever physically fight? Yes___ No___ Don't Know___

29. Have you ever been forced to have sex when you didn't want to? Yes ___ No___ Don't Know___

30. Have you ever worried about hurting yourself or someone else in any way? Yes___ No___ Don't Know___

31. Do you ever worry about the friends or associates that you hang out with? Yes___ No___

32. Do you ever worry that things you do are dangerous? Yes___ No ___

33. Do your friends or family members ever worry that things you do are dangerous? Yes___ No___ Don't Know___

34. Could you get a gun if you wanted to? Yes____ No ___

35. Do your friends or family members ever worry about your safety? Yes ___ No___ Don't Know___

36. In general, when it comes to your own safety, how often do you feel unsafe?

1	2	3	4	5
Always	Often	Sometimes	Rarely	Never

37. *How much do you want to talk to your counselor here about your safety?*

1	2	3	
Not At All	Somewhat	Very Much	Don't Know ____

YOUR HEALTH

Many things can affect you health including how you feel about yourself your sexuality your family your friends your community and seeing drug and alcohol use Here at the Adolescent Health Center we can help you understand yourself your health and your body We can help you with any concerns or questions

Please answer as many of the following questions as you can

38. Do you have any health problems or worries? Yes___ No___ Don't Know___

39. Do you worry that you are overweight or underweight? Yes___ No ___

40. Do you throw up to lose weight or binge (really over eat)? Yes___ No ___

41. Do you ever try to go a whole day or days without eating? Yes___ No ___

42. Do you worry that you sleep too much or too little? Yes___ No ___

43. Do you have frequent headaches or stomach aches? Yes___ No ___

44. In general, when it comes to your own health how would you say you are doing?

1	2	3	4	5	
Very Poor	Poor	Average	Well	Very well	Don't Know ___

45. How much do you want to talk to your counselor here about any health issues?

1	2	3	
Not At All	Somewhat	Very Much	Don't Know ____

YOUR HEALTH. SEX AND SEXUALITY

46. How would you describe yourself? (Check any below)

Straight (Heterosexual) ___ Bisexual ___
Gay ___ Transgender ___
Lesbian ___ Not sure ___

47. Have you been taught about your body and sexuality? Yes___ No___ Don't Know___

48. Have you ever had sex? Yes___ No___

49. Have you ever been pregnant or gotten someone pregnant? Yes___ No___

50. Have you ever thought about testing for HIV/AIDS? Yes___ No___

51. Have you ever used drugs or alcohol to make sex easier, longer, or more fun? Yes___ No___ Don't Know___

52. Do you ever worry about anything to do with sex, your body or birth control? Yes___ No___

53. Do you have any questions or concerns about sex, your body, or birth control? Yes___ No___ Don't Know___

54. Do your friends or family members ever worry about your sexual behavior? Yes___ No___ Don't Know___

55. When it comes to sex, your body and birth control how would you say you are doing?

1	2	3	4	5
Very Poor	Poor	Average	Well	Very well

56. How much do you want to talk to your counselor here about anything to do with sex, your body or birth control?

1	2	3	
Not At All	Somewhat	Very Much	Don't Know ____

YOUR HEALTH: CIGARETTES ALCOHOL AND DRUGS

57. Has anyone ever offered you any drugs? Yes___ No___

58. Do you spend time with anyone who uses drugs or alcohol? Yes___ No___

59. Check any of the following that you have tried.

___ Tobacco (cigarettes, snuff, chew)

___ Alcohol (beer, wine, wine coolers, hard liquor)

___ Marijuana (pot, weed, reefer, boom, chronic, blunts, joints)

___ Other drugs (e.g. crack, cocaine, ecstasy, special K, LSD, acid, glues, heroin, uppers, downers, steroids)

60. In the last month have you used alcohol, marijuana or any other drugs? Yes___ No ___

61. Have you ever worried about your use of alcohol or drugs, or tried to cut down? Yes___ No ___

62. Do you know someone whose drug or alcohol use worries you? Yes___ No ___

63. Do your friends or family members ever worry about your alcohol or drug use? Yes ___No___ Don't Know___

64. In general, when it comes to alcohol and drugs how would you say you are doing?

1	2	3	4	5
Very Poor	Poor	Average	Well	Very well

65. How much do you want to talk to your counselor here about anything to do with alcohol or drugs?

1	2	3	
Not At All	Somewhat	Very Much	Don't Know ____

YOUR PERSONAL LIFE

66. Do you have any worries about your friends or associates? Yes ___ No ___

67. Do your family members ever worry about your friendships? Yes ___ No ___ Don't Know ___

68. In general, when it comes to friendships how would you say you are doing?

1	2	3	4	5
Very Poor	Poor	Average	Well	Very well

69. How much do you want to talk to your counselor here about friends or associates?

1	2	3	
Not At All	Somewhat	Very Much	Don't Know ___

70. Has anyone close to you died in the last year? Yes ___ No ___

71. Do you have any worries about your family or home life? Yes ___ No ___

72. In general, when it comes to your family or home life how would you say you are doing?

1	2	3	4	5
Very Poor	Poor	Average	Well	Very well

73. How much do you want to talk to your counselor here about your family or home life?

1	2	3	
Not At All	Somewhat	Very Much	Don't Know ___

74. Do you ever worry about any other personal things that we have not asked you about today? Yes ___ No ___

75. In general, when it comes to your personal life how would you say you are doing?

1	2	3	4	5
Very Poor	Poor	Average	Well	Very well

76. How much do you want to talk to your counselor here about your personal life?

1	2	3	
Not At All	Somewhat	Very Much	Don't Know ____

77. Do you consider yourself a spiritual person? Yes ___ No___ Don't Know___

78. How often do you attend religious services (Church, Synagogue, Mosque, Temple, Other)?

1	2	3	4
Never	Rarely	Sometimes	Often

THANK YOU FOR ANSWERING THESE QUESTIONS IS THERE ANYTHING WE FORGOT TO ASK ABOUT?

IF THERE IS FEEL FREE TO WRITE IT DOWN BELOW

OR TO TELL YOUR COUNSELOR ABOUT IT

79. Please write down any personal views or concerns that we forgot to ask you about

80. If you have any questions or comments please write anything you want to in the space below:

APPENDIX D: The FamQuest

The following questions are about your adolescent and your family. In order for us to help your child, we need you to answer the questions which follow.

Your answers will be kept confidential and you can discuss them with the person doing the intake with your child.

Please answer as many questions as you can so we can understand important situations and events in the history of your family. Your responses will help us provide the best possible care for your child and family.

If you have any questions please ask the person doing the intake with your son or daughter.

[illegible]

1. Name of Your Adolescent:____________________

2. Your Adolescent's Date of Birth:____________

3. Your Name:____________________

4. Your Relationship:

Mother_____ Father______ Other (please write in_________________________

5. How do you rate your son/daughter's school?

1	2	3	4	5
Very bad	Bad	Average	Good	Very good

6. How do you feel your child is doing in school?

1	2	3	4	5
Very poorly	Poorly	Average	Good	Very good

7. How often do you worry about your child's safety in general?

1	2	3	4	5
Always	Often	Sometimes	Rarely	Never

8. How often do you worry about your child's safety in school?

1	2	3	4	5
Always	Often	Sometimes	Rarely	Never

9. How often do you worry about your child's safety in the neighborhood?

1	2	3	4	5
Always	Often	Sometimes	Rarely	Never

10. How often do you worry about your child's health?

1	2	3	4	5
Always	Often	Sometimes	Rarely	Never

11. How often do you worry about your child's sexual behavior?

1	2	3	4	5
Always	Often	Sometimes	Rarely	Never

12. Do you believe your daughter/son has tried:

Tobacco	Yes___	No____
Alcohol	Yes___	No____
Drugs	Yes ___	No____

13. How often do you worry about your son/daughter's ability to handle the issues around drug use?

1	2	3	4	5
Always	Often	Sometimes	Rarely	Never

14. How often do you worry about your son/daughter's friends?

1	2	3	4	5
Always	Often	Sometimes	Rarely	Never

15. How do you feel that your child is doing in his / her personal life?

1	2	3	4	5
Very poorly	Poorly	Average	Well	Very well

16. Do you consider your family religious? Yes_______ No_______

17. How often do you and your son/daughter talk about issues?

1	2	3	4	5
Always	Often	Sometimes	Rarely	Never

18. How well do you and your son/daughter talk about issues?

1	2	3	4	5
Very poorly	Poorly	Average	Well	Very well

Your Family

Understanding your family is important to us in [illegible] us to help your adolescent. Often events which have happened in the past can help us understand things that are happening now. Please help us by filling out as many of the questions below as you can. If you have any questions about this, your [illegible] counselor will be glad to talk with you more.

Please circle yes or no for the following statements.

- If the statement is true, and has happened in the **past six months** please circle **" yes" in the first column**.
- If the statement was true **in the past** please circle **"yes" in the second column.**
- If the statement applies for the past six months, **and** for a time longer than that, pleas circle yes in **both** column.
- If the statement does not apply, **please circle no in both columns.**

	In the last 6 months	More than 6 months
19. Family has moved a lot.	YES NO	YES NO
20. Chronic illness in the family.	YES NO	YES NO
21. Family member has been victim of crime.	YES NO	YES NO
22. Family member has physical handicap.	YES NO	YES NO
23. Child was in a foster home.	YES NO	YES NO
24. Child has been physically abused.	YES NO	YES NO
25. Parents have been unemployed or lost job.	YES NO	YES NO
26. Family members have had serious arguments.	YES NO	YES NO
27. Physical fighting between adults in the home.	YES NO	YES NO
28. Child takes care of others in the family.	YES NO	YES NO

29. There has been a psychiatric hospitalization of a family	YES	NO	YES	NO
30. A close family member has died.	YES	NO	YES	NO
31. Parents are separated or divorced.	YES	NO	YES	NO
32. Chid has lived with a relative.	YES	NO	YES	NO
33. Place we live in is very crowded.	YES	NO	YES	NO
34. Neighborhood we live in is unsafe.	YES	NO	YES	NO
35. There have been physical fights between siblings	YES	NO	YES	NO
36. Family known to C.W.A/ACS.	YES	NO	YES	NO
37. Family member has alcohol problem.	YES	NO	YES	NO
38. Family member has a drug problem	YES	NO	YES	NO
39. Family has been homeless.	YES	NO	YES	NO
40. Friend died.	YES	NO	YES	NO
41. There has been a separation of siblings.	YES	NO	YES	NO
42. Child has been sexually abused.	YES	NO	YES	NO
43. Other member of family has been sexually abused or assaulted	YES	NO	YES	NO
44. Family member arrested or in jail.	YES	NO	YES	NO
45. Other Family Problems: ____________	YES	NO	YES	NO

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