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Facilitating the Utilization of Evaluation... A Rocky Road

by

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In a rational world it may be an appropriate assumption that evaluation findings would flow from the evaluator on to the organizational change consultant, and finally to the utilizer. Confirming evidence of this logical flow seems to maintain a low profile. In fact, its inconspicuousness has given rise to considerable concern. For example, the Federal Council on Science and Technology, in response to public and political expressions of concern about the utilization of Government-supported knowledge, established a subcommittee on technology transfer and utilization. An early discouraging finding was that only one-fourth of one percent of the Federal R&D budget is dedicated to the knowledge utilization process.

More specifically, the record on utilization of evaluation results is not good. As more sophistication and interest in evaluation grows, Federal agencies give more support as well as pressure toward program evaluation. Program staffs are too often responding to the same enthusiasm accorded an unwelcome visitor in the house. The evaluator submits his report only to find his customer making little or no use of it. In many cases, there is evidence that reports have not even been carefully read, and many other reports seem to have little or no effect on the decisions subsequently taken. Granted, many evaluation reports are too fragile or trivial to justify important and costly

changes in practice, but it still remains true that ideas of high merit are also ignored in practice.

In the field of mental health evaluation there is disturbing evidence of the same concern. Attkisson and co-workers (1973) visited evaluators in 60 community mental health centers. They found a growing demoralization among persons involved with evaluation. Windle and Volkman (1973) have reported an apparent disenchantment on the part of CMHC administrators with respect to the utilization payoff from evaluation.

Beyond the findings of Attkisson's study referred to above, we continually hear the disillusioned expressions of evaluators whose greatest promise of reward is in seeing change occur in response to their knowledge contributions. The reinforcers for basic researchers, such as acceptance of articles by journal editors and acclaim of colleagues, often are absent at this important level of applied endeavor. Not least among causes for concern is the fact that the supporters of evaluation endeavors are asking hard questions; reductions in funding may grow from the failure to get cogent answers. Evaluation is still receiving growing support and the number of persons choosing to work in that field is accelerating. But, as many have recently predicted, a sharp fall from the evaluation fad—if that's what it is—may soon occur.

Well, that is the problem as we see it. Is there a solution to propose? Our suggestion is simply this: What seems to be needed most is strong concern regarding the transfer process at the interfaces of evaluation and desired change. There is an extensive literature to which a motivated person might turn now. We estimate that the diffusion and utilization literature now exceeds fifteen thousand citations. Books that are now available include Rogers' book, *Diffusion of Innovations,* (1971) Havelock's new book, *Training for Change Agents,* Zaltman's volume, *Innovations and Organizations,* (1973) and, of course, there are other notable attempts to pull together information on techniques of planning for change. Our position is that even if one does not wish to specialize in the technology of change consultation the observance of factors influencing the utilization of evaluation findings by evaluators will sharply increase the probability of impact from findings. There is substantial evidence that attention to those factors does indeed lead to higher payoff of, at least, evaluation research.

But what might one expect to find as the reward for her or his efforts? First of all, the rewards would be the solutions of the problems that were mentioned earlier; namely, increased sense of fulfillment through seeing benefits occur as a result of the utilization of one's findings. Hardly an insignificant consideration to some who may be in private consultation is the fact that the demand, said to be quite lucrative, is growing for consultants on organizational change. And we would all hope that the broad scene reward would be a restoration of the confidence in the practical benefits from evaluation and the maintenance of confidence in evaluation support.

Of course there also are problems.

Problem No. 1: Fairweather and co-workers (1974), who have studied the adoption of a single innovation, perhaps as thoroughly as any has even been researched, offer this at the top of the list of their principles drawn from their observations: Change is hard work. It requires great tolerance for frustration

and exceptional perseverance. We strongly agree. There is no conclusion which appears more valid than that one.

Problem No. 2: The person willing to serve in the deliberate capacity of change consultant is likely to meet a bitter welcome. To assume that decision-makers and program persons in human services—or any other organization for that matter—are eageriy seeking change so that they may have greater goal attainments simply is to insult the imagination. This is particularly true for considering change stimulated by solid knowledge. It is a fact of life that many decisions must be guided by many pressures having little to do with knowledge—social, political, person, and circumstantial. A closely allied matter is that being confronted with the facts indeed does restrict the degrees of freedom of the decision-maker. Not only a little knowledge, but a lot of knowledge, can be extremely threatening in the eyes of many. Presented with knowledge one has the choice of adopting it as outside pressures may dictate, ignoring it as most of us are inclined to do, or refuting it as is so often the case with published evaluation findings.

Problem No. 3: As excellent as is the job that has been done in sifting, sorting, and distilling the literature on diffusion and utilization, the array boggles the mind. There are the approaches of Lippitt, of Jenkings, of Jung, of Watson, and Greiner, and Reuben, and Havelock, and Rogers, and Glaser, and the so-called theories of Zaltman-Duncan-Holbek, and of March and Simon, and of Burns and Stalker, and of Harvey and Mills, and of Wilson, and of Hage, and Aiken. (see Davis & Salasin citation, 1975) There are the processes of problem-solving, of research-development-and-diffusion, of social interaction, of linkage, of reward structure, and of action research, and on to conflict theory and intervention theory.

One might gain the impression that there is something a bit short of consensus. As one might guess from the profusion of proffered approaches the literature behind the diverse attempts to order information on change leaves a margin of opportunity for validating research. Much of the literature consists of asserted notions. A large portion consists of observations of experiences. There are, of course, many contributions from those who have scientifically observed change in process. The number of true experiments testing techniques facilitating knowledge transfer almost equals the number of ferns in the desert. The lamentable thing is that persons seriously concerned with employing planning change in either the design of studies or in the adoption of findings are apt to turn away in frustration, or perhaps at best select one or two techniques and rely on those.

PLANNING FOR CHANGE: THE "A VICTORY" APPROACH

We should acknowledge that there is divided opinion about whether the adoption of change by an organization or by a single individual actually is a behavioral event. We hold that it is. Backing this assertion are the writings of such people as Brown (1973), Sheppard (1965), and others. The essence of organizational functioning is not T.O.'s, functional statements, and policy manuals. It is human behavior. In a more complex way, of course, organiza-

tions have their motivational intensities, resistances, value systems, and characteristics that function like egos, relative abilities, patterns of action, and they respond to environmental circumstances in much the same way as individuals.

Some change approaches already incorporate the human orientation. For instance, Tavistock groups often are used in organizational development. They seem to be oriented toward psychoanalytic notions. Notions derived from learning theory, or more specifically, behavior modification, would apply as well. In the past we have incorporated a learning theory–derived conception into what we term the A VICTORY model. A VICTORY is an acronym offered simply to help recall the eight variables considered necessary and sufficient to account for organizational behavior. It is a translation of learning theory terms appearing on the right side of the equals sign, with specific program action, or organizational behavior, on the left. This model does serve as a more theory-based way to sort out and encompass specific principles and techniques falling out of the change literature.

In looking at the A VICTORY we see the following constellation as critical. The motivation which is present, the availability of feasible solutions for patterns of action–contingent behavior, some might call it; the resistances and incentives related to proposed solutions, the consequences, if you will. The self-concept of the organizations involved, the consistency with accustomed ways of carrying things out or primary beliefs; the ability or capacity to carry out the proposed solution, whether in terms or funds, staff, training, facilities, etc.; and the prevailing circumstances over stimulus conditions which are relevant in terms of the kinds of action with which they will be compatible.

Quite obviously these are not discrete factors occurring in any sort of linear sequence. As is true of determinants of all behavior they operate more as the circles of a *Venn* diagram changing in size and position, and certainly overlapping. Some persons may feel that this is more effort and thought than they care to give to facilitating the transfer of knowledge into action. But we might take comfort in what is known as the Pareto principle. Zilfredo Pareto was an Italian economist and sociologist who was active around the turn of the century. Pareto's statistical analysis revealed that 80% of the results in any human endeavor come from about 20% of the action. The trick is to know what 20% of the determinants to which to devote one's attention.

We feel that the eight variables represented in this model and analysis of the organization in terms of these variables, can account for whether you can bring about change in that organization or not. An understanding of where the organization is on each of those variables can show you what your problems might be, and what conditions you are going to have to try to manipulate in order to try to serve as an effective change agent within the organization. In terms of facilitating the use of evaluation findings, the following type of analysis of variables needs to be undertaken before initiating a planning change process.

The first variable is *Ability.* Essentially, this means the resources that the organization has. Do evaluation findings call for a change that involves more money than is present, additional staff training, or new staff? If any of these

things are problematic, then you know there is going to be difficulty in implementing the change.

The second, the *Values,* is the "set" of the organization. If it is a psychoanalytic one and you are recommending behavior modification again, you know you're really going to have to do a lot of work in this area in order to try to gain some sort of acceptance.

The third is the *Information* itself. Are evaluation findings that have come out of this evaluation, credible, cogent, and clear? Do the organizational people really understand what you are talking about? Do you have to do a lot more work to simply try to communicate the essence of what the change might be.

The next two are really interrelated, but are broken apart for purposes of forming the acronym. They are the *Circumstances* and the *Timing* of the organization. Credible findings may be available that would argue well for a change, but the budget cycle may be all wrong. A new director may have just come in who would pose a special problem. Basically, do circumstances and timing argue well for this kind of change, or do they not?

The next variable is the *Obligation.* What kind of need does the organization have to make for this kind of change? Again, the evaluation findings may suggest a change that would be a very optimal one for them to make but if it does not relate to any felt needs that they might have, then there is no particular motivation to go ahead and make the change.

The next is *Resistances,* and this is both the "up front" resistances, and unconscious resistances. Any change means that some people will lose and others will gain. Who is going to lose status because of it? Who is going to have a new title because of it? What sort of organizational changes are going to come about, that will evoke a lot of personal resistance?

The final variable is the *Yield.* If the organization does go ahead and make this change, what is the improvement going to be? How much is it going to benefit? Whom? Is the yield going to be enough to really sustain them in this new practice, or will they try it, and because of the lack of yield, simply fall back into old patterns? We have found that the construction of a simple "Readiness for Change" scale, which is presented at the beginning of this book, relating to each of these variables proves exceedingly helpful in measuring the readiness of a given organization to adopt a given change. In practice so far, use of this scale seems to have had considerable validity. It is a real fact that the significance of these determinants of change is not a matter of our option. They play their roles in the drama of organizations willy-nilly despite our wish to ignore them. Either they master us or we master them. There are no quick tricks in the change business. But at least by giving attention to these factors we have a fighting chance of collaborating with inevitable change.

As a final caveat, we believe that there are three possible stances the evaluator can take within the organization with regard to change. Once the evaluation has been planned, the design completed, the level of responsibility that he or she can assume would be: first—no responsibility—only the obligation to turn over the results to whoever contracted for the evaluation; second would be to turn over the results and then monitor the use of the results to

make sure they are not misinterpreted or misused in a manner beyond the intent of the original study; third would be for the evaluator to decide to serve as a change agent to facilitate the implementation of the results within the organization. If the evaluator does not serve as a change agent himself, then he or she may coordinate his or her activities with someone who is serving in this capacity.

In discussions that we have had with people around the country about which stance to take, we believe the very best stance is to begin initially with an agreement between the program manager and the evaluator as to what will be done with the results and as to the role of the evaluator vis a vis change, at the outset, before the evaluation is undertaken. In this way, there can be an agreement that certain kinds of results will remain private and others can be made open to public scrutiny, and that the evaluator is or is not committed to following through with the change process. Once this contract is settled upon, it is an ethical matter to maintain it.

In the following section of this chapter we will illustrate this process of change consultation organized around the A VICTORY model which we are proposing for evaluators. The procedure involves an initial administration of the "Readiness for Change" scale to representatives of all the groups to be involved in the desired change (in the case of the evaluator, the desired change may flow from what evaluation findings have indicated is needed with concurrence from program officials). Then the feasibility of the change is assessed from the standpoint of the A VICTORY variables and action steps are developed under each of the variables. And finally, the process of change is monitored with remedial actions taken at each step of the way. The state mental hospital used as the example in this case is a real hospital which cooperated with us in this planned change experience, which for the interest of privacy we will call Oakville.

ORGANIZATIONAL CHANGE CONSULTATION: A CASE STUDY

Oakville State Hospital: Laboratory for Change

Oakville State Hospital was a small, rural hospital that served largely geriatric patients who had been long-time residents of the hospital. The residents were predominantly male, black, with diagnoses of mental retardation and/or chronic brain syndrome. At the time we began our consultation the hospital program had been one of "custodial care" with no specific patient programming. Recently, however, a new director and energetic group of younger lead staff had agreed upon the need to "move up" from custodial care to some type of program that was more rehabilitative.

At the invitation of a spokesman for the top staff of Oakville State Hospital, we began a series of consultations with Oakville staff regarding possible strategies for proceeding with and implementing hospital-wide changes in patient programming. The consultation "contract" that was agreed upon at the outset was that NIMH staff would offer assistance in planning for and guiding proposed changes, and the Oakville staff would

provide feedback in order for NIMH staff to assess the feasibility of their particular approach to planned change.

Readiness for Change: Problem Assessment

Subsequently, first we engaged in a series of interviews with key personnel to be involved in the change. Structuring these interviews around the model that represents our approach to planned change, A VICTORY, we tried to assess the readiness of the organization to assimilate the particular innovations they wished to implement in terms of the eight variables represented in the model.

After we completed these interviews with key staff to elicit information, attitudes, and beliefs relevant to each of these variables, we completed a "Readiness for Change" scale* designed to assess the likelihood that the particular change under consideration could be accomplished. Then we asked the staff we had interviewed to complete, individually, the same "Readiness for Change" scale in order to determine where they stood on these same issues, to assess the fit between their views and ours, and to identify the problem areas that needed most consideration in effecting the change. The results of our pooled ratings are presented on the next page, followed by an explication of the possible "action steps" that might be taken, organized by A VICTORY rubrics, to maximize the success of the planned change. The results of this assessment are indicated below:

READINESS FOR CHANGE SCALE

Range of Scores (0-100)
Higher Scores = Greater Likelihood Success

Planned Change: Shift from custodial approach of "doing for" patients to therapeutic approach consisting of grouping patients by ability levels, introducing self-care, milieu therapy, active program participation by patients when feasible.

	Oakville Staff	NIMH Staff
A	77	58
V	71	73
I	78	83
C	80	92
T		
O	85	82
R	86	60
Y	77	82
	Overall Score = 79	Overall Score = 75

As this chart makes clear, both Oakville Staff and NIMH Staff were very congruent in their estimate of the likelihood of success in implementing the shift from custodial care to a program stressing self-care and activity. It appeared that there were three chances out of four that the innovation would "make it." There was some divergence of views, however, with respect to

*The complete Readiness for Organizational Change Guide appears on pages 15-20.

difficulties to be encountered in the areas of *Ability* and *Resistance,* and a more detailed analysis of these areas is presented in the following discussion of sample possible action steps to be employed under each A VICTORY rubric.

A = ABILITY Oakville = 77 NIMH = 58

The lack of close correspondence of scores on this variable is reflective of the differing statements by Oakville and NIMH staff as to the nature of the problem. Both were agreed on the necessity for additional training for ward personnel who would conduct the new programs, but NIMH staff gave greater weight to the potential problems inherent for ward staff in the tug-of-war between their traditional housekeeping and patient care responsibilites. We also felt that the old rotational system for staff from ward to ward and from shift to shift would have to be altered and tailored to the new programs. We, too, saw the need for training for ward personnel, and wondered how that would mesh with new program responsibilities, housekeeping, patient care, and rotational demands. We felt this to be a problem area whose resolution was very important to the planned change.

Sample action steps suggested:

- Staff assigned to first self-care unit be relieved of housekeeping as much as possible, little rotation
- Intensive training for this same staff, attempting to build special competence, self-esteem, full reinforcement
- Attempt to pool resources to bring a trainer back from the Michigan program to be "on call" to this group for a week or so
- Encourage ward staff trained first to serve as trainers for ward staff throughout the hospital.

V = VALUES Oakville = 71 NIMH = 73

Both Oakville and NIMH staff were quite parallel in their view of how the values would support change. The group felt that the planned change fit well with the written goals of the hospital, that it was harmonious with the revitalization sentiments of the top leadership, but that it was contrary to the assumptions and traditions of the long-term ward staff. In light of this latter condition, the following was discussed as suggested action steps:

- From the outset, the innovation should be introduced as a "ward staff project" with, as mentioned in "A", staff purposefully trained as trainers for other hospital staff so they were seen as the experts to sustain the change
- Issuance of frequent progress reports, prepared by ward staff, perhaps in the form of a newsletter that would serve a lateral staff-to-staff communication function
- Encourage ward staff to initiate some type of process evaluation of their own design with benchmarks to rate their own progress.

I = *INFORMATION* Oakville = 78 NIMH = 83

In terms of the information available about milieu therapy, the information needed to plan, implement, and sustain the change, both groups were fairly confident that it was available and informative. Agreement was firm that the desired innovations were to group patients by ability levels, to develop a varied daily routine, to encourage independent goal-directed activity, and to do so in as democratic and participative fashion as possible. All parties realized, however, that ward staff would need training, repetitive training, in how to do it, and so the following action steps were discussed:

- Arrange for demonstrations to be held frequently for each new program to be introduced
- Design "card sets" that would list, in order, the specific procedures for each new program that ward staff could pick up and use again and again
- Develop a handbook or procedures manual detailing the steps involved in each program, much as a pilot has a checklist to countdown before taking off
- Stage trials of each new program with feedback from participants used to modify procedures.

C & T = *CIRCUMSTANCES & TIMING* Oakville = 80 NIMH = 92

While both groups rated *C & T* as very propitious, the NIMH rating was considerably more optimistic. Perhaps this was due to the NIMH staff immersion in the change literature, so that it appeared to us that all *C & T* variables were present to usher in successful change. Some of these are: the award of a first-time one year training grant to stimulate staff growth; the relatively new top staff eager to make their mark on the hospital; the completion of patient evaluations so that grouping by ability level could occur; the renewed interest of State authorities in Oakville due, in part, to the above; the recent success of reality orientation and occupational therapy programs; and, finally, the prevailing cultural Zeitgeist for patients' rights and full treatment within institutions. Due to the force of these factors, we had little to suggest to improve on *C & T* except for the following action steps:

- Set up goals and a tentative timetable in order to reinforce the momentum of the events already in motion
- Anticipate the new needs created by new programs in the coming year, budgetwise, in requests to the State (i.e., housekeeping staff); perhaps budget could be submitted in full milieu therapy format.

O = *OBLIGATION* Oakville = 85 NIMH = 82

Here again, both groups rated the sense of obligation, the need to act, to do something about patient inactivity, as very strong. The perception was strong and mutual that the inactivity of patients was leading in many cases to a loss of a sense of personal identity and touch with reality including a consequent physical deterioration. Concern was expressed, however, as to

whether the ward staff was really aware of the consequences of inactivity for these patients, or if they just took it for granted as their natural state. Therefore, the following action steps were discussed as a means of heightening the ward staff's sense of the obligation to change:

- Stage a series of "role reversal" experiences for staff – i.e., have staff take chairs, face the wall, remain *totally inactive* for 1/2 hour and observe changes within selves; sped a day acting as if they had some physical handicap, etc.
- In a series of columns or features in a hospital newsletter, dramatize by case study the plight of inactivity
- Arrange for a series of films to be shown, cassettes made available, where this problem is discussed
- Dramatize to staff that if this hospital cannot demonstrate that it provides better care than a nursing home, its future may be in jeopardy.

R = *RESISTANCES* Oakville = 86 NIMH = 60

The rather considerable difference between the two ratings means that NIMH staff rated the resistances to be encountered in the process of implementing the change far more strongly than Oakville staff did. We based our assessment on the potential difficulties to be encountered with the ward staff as they shifted from the traditional way of doing things and acquired new skills. Our estimate of the problem areas was as follows: first, to have to change–in any way at all–can often imply a strong critique arousing defensiveness on the part of ward staff who already feel overworked and underpaid; second, implementing a "participative management style" necessary for the program to occur was altering the old power structure with subsequent anxiety and jockeying for place; third, staff may really not have enough time due to housekeeping responsibilities and rotational problems; fourth, ward staff belief that present patients are "hopeless" and cannot respond to efforts to help them; and lastly, the fact that the new programs are simply contrary to the hospital traditions of fixed routines and "doing for" the patient. In light of these potential problems, the following action steps were suggested:

- Continue the broad participative approach already initiated, but make the first self-care unit a ward staff program with *elective* participation
- Involve staff on wards not included in first implementation of new program by having them form an advisory group to the self-care unit so that their opinions are weighed in shaping the new program
- Encourage ward staff in both new and old program to hold "peer discussion groups" where problems are thrashed out and *then reported back* to top management
- Start the first self-care unit on a trial basis for two weeks, then use feedback of involved staff to make necessary changes so they do not feel initially that they are in an immutable contract that they have no voice in changing–let them shape it as their program.

Y = YIELDS Oakville = 77 NIMH = 82

There was general consensus regarding the potential benefits to accrue from moving ahead with the planned change. The benefits ranged from: the improved standing and viability of Oakville in public and State eyes; staff development in terms of learning new skills, pride in work, and feelings of personal accomplishment; and fulfillment of the mission of growth and a better life for the patients. For the new program to be a success however, there was a strong consensus that the benefits to all involved should be as strong and reinforcing as possible. Therefore, the following action steps were discussed:

- Establish an evaluation, using a "Ward Behavior Rating Scale" for those patients to be moved to the new unit *before* they are moved, with regular measures taken after the move
- Display the results of the evaluation graphically on large colored charts outside the Director's office and on the ward itself
- Start a patient newsletter with contributions by the more active, i.e., testimonials, etc.
- Arrange for awards for patients doing well, Certificates of Merit, etc.
- Provide visibility and reinforcement for ward staff leaders through staff newsletter, staff Certificates of Merit, staff contributions to own newsletter.

With the completion of this problem assessment phase in the application of the A VICTORY model, which is conducted to estimate the probability that change will occur and to guide action plans toward enhancing the likelihood of change, one then turns to defining goals, establishing timetables, and drafting a plan of action to steer implementation as illustrated in the following sections.

The first phase in the application of the A VICTORY model, problem assessment, had been successfully completed with the comparative analysis of Oakville and NIMH responses to the Readiness for Change Scale, and the subsequent determination that there were three chances out of four that the innovation—a shifting from a custodial to therapeutic treatment style—would "make it." Problem areas in implementing the innovation had been identified, action steps developed to maximize success, and a general spirit of high purposiveness prevailed.

Readiness for Change: Goal Definition

Oakville staff were extremely vigorous in their determination to move full speed ahead with the plans that had been previously discussed. With real imagination, dedication, and "elan," they had drafted a very comprehensive statement specifying *what* the change was to consist of, in words meaningful to ward staff, that had been used as basis for small group, face to face, orientation sessions for all hospital staff. The role of the program planning committee had been further defined, buttressed, and reinforced, with real authority delegated to them. The statement of what the *change* consisted of had been helpful in grouping the patients by self-care ability level, and they were in effect "ready to go." Most importantly, it was apparent that there was a

true commitment to making the implementation of the change a "ward staff project" with an opportunity for real growth and development on the part of the staff.

At this juncture, the group agreed to work together to develop their goals through an MBO system that would guide them through the development of the Self-Care Unit. The following emerged as the statement of intent for this unit:

Self-Care Unit

Management by Objectives

Goal — To prepare patients to live outside the hospital.

Objective 1 — To teach them to be as independent of nursing care as possible within the hospital.

Objective 2 — To foster employee morale through the development of teamwork.

Objective 3 — To develop a specific treatment plan for each patient tailored to his or her needs.

In terms of the evaluation system, the "how do we know if we have reached our objectives?" The following approach was utilized.

Using an "Objective Attainment Scaling" approach derivative of Goal Attainment Scaling, it was decided to start with the first objective – that of independence. The following type of matrix was outlined:

Objective: Patient Independence of Nursing Care

Highest Expected	↑
Higher than Expected	↑
Expected	Within 3 months over 50% of the patients on the Self-Care unit will "pass" on the Self-Care Rating Scale
Lower Than Expected	↓
Lowest Expected	↓

Readiness for Change: Action

With the general expectation and commitment in mind that patients would be reassigned and residing on their new wards by April 15th, and that some self-care training programs would be operational by May 1st, the following action plan was developed, with action steps organized by A VICTORY rubrics, and target deadlines agreed upon:

SELF-CARE UNIT ACTION PLAN

A VICTORY Rubrics	Action Step	Timing
Information	Formulating training guides	April 1
	Developing lesser plans	June 15
	Developing treatment plans	April 15
	Establishment of Committee on Self-Care Programs	April 30
Ability	Assign Ward personnel	April 1
	Demonstrations by Michigan group	April 30
	Training necessary skills to self-care team	April 30
Values	Selection of ongoing self-care coordination for whole hospital	June 15
Resistances	Orienting training supervisors Expanding Program Planning Comm.	April 1
Yield	Selection of Self-Care measure.	April 30

With this first action plan agreed upon, subsequent steps were seen to be those of monitoring progress, revising and updating the actual plan as milestones are achieved, and continuing analysis of potential problem areas and why lapses in meeting deadlines might occur.

Readiness for Change: Follow Through

A review of the progress of Oakville State in implementing and sustaining hospitalwide milieu therapy program demonstrated that the following issues had emerged as pivotal in the continuing attempt to "move-up" from custodial care:

1. the criteria utilized in determining which ability grouping is appropriate for each patient – some patients on the Self-Care Unit were physically able to participate but mentally unable, while others in the lower groups were physically handicapped but mentally alert.

2. the long range impact of grouping by ability levels when "the rich get richer" and "the poor get poorer" with profound implications for both staff and patients at the lower levels.
3. the observable consequences of change – however well planned – on these patients who live out a thin edge of adjustment in a non-changing environment.

Oakville State had continued to do a laudable job in marshalling and carefully targeting resources for maximal impact, and events appeared to be smoothly on course, but it was to the above "unintended side effects" that we turned our attention. The specific problems representative of these three issues will be outlined below in terms of the A VICTORY model, as a means of assessing these variables that may need additional time and attention in order to sustain the new program, and hospital "Zeitgeist."

Sustaining Planned Change: A VICTORY Analysis

A – Ability – Capacity to carry out solution – staff, funds, space, sanctions

The staff had been well mobilized to carry out the new program. Aides in the Staff-Care Unit were being trained, and staff in the units down to the Low Basic Unit were already moving ahead with programs preparatory to the time when they would be trained. Among these groups spirit was excellent. The staff in the Low Basic ward and the infirmary, however, were of a different outlook. They felt overburdened by the care of regressed and physically disabled patients who could show no sign of progress. They felt that all of their time was devoted to *custodial care*, and many indicators of trouble had appeared such as staff illnesses, early resignation, a higher-than-usual patient mortality rate, etc. Staff on these wards had also ceased to carry out programs that they had already learned–such as reality orientation. Resentments had grown toward the staff on the upper-level wards who seemed "to have all the fun."

The provision of necessary funds, space, and sanctions continued to provide no problems.

V – Values – Predecisions, beliefs, manners of operating, and characteristics of the organization

Oakville as an institution appeared to have made an excellent adaptation in this area. Staff were mobilized to a new style of operation, participative management had taken hold, and new power alliances appeared to be smoothly effected.

I – Information – Information relevant to taking steps to solve the problem

"The problem" at that point in time appeared to have shifted from that of needing to know how to implement and sustain milieu therapy to that of *how to effectively group patients for maximum patient and staff benefit.* Does negative modeling occur when all regressed patients are together? Will a few alert patients placed among regressed serve as positive role models, or will they also regress? Can staff maintain morale to work with regressed patients who require full physical care? How can staff be motivated to begin self-care programs with the severely regressed? What weighting should be given to physical vs. mental capabilities in assigning a patient to given level-of-self-care unit? It appeared that much more information was needed at this point about these questions.

C & T – Circumstances & Timing – Prevailing factors pressing for or detracting from certain actions, synchronizing with other significant events

These variables did not appear to have shifted in any significant way, except that continuing attention was needed to plan for the phase-out of the training grant and the subsequent departure of the person serving as trainer to ward staff. The arrival of a parttime psychologist skilled in behavior modification techniques to be assigned to the Low-Basic ward offered real promise for building a "program" in that ward.

O – Obligation – Felt need to do something about the problem

Again, in terms of the shift of "the problem" from that of needing to know how to implement and sustain milieu therapy to that of *how to effectively group patients for maximum patient and staff benefit,* the felt need to do something appeared not to be as strong as it might be. The success of the Self-Care unit, the good "local inventiveness" and esprit of the other staff outside of Low Basic and Infirmary staff, was such a compelling reinforcement that it perhaps obscured the need to develop stronger programs and perhaps re-group at the lower levels.

R – Resistance – Frontstage and backstage concerns for loss if specific action is taken

Resistance did not appear to be a problem in any area except for the Low Basic and Infirmary. There, neither staff nor patients were adapted to the change. Staff felt overwhelmed, unable to cope, and were seriously overburdened and lacked motivation. Patients were regressing, often back in wheelchairs, requiring spoon feeding, urinating, etc.

Y – Yield – Felt rewards, benefits to program participants and consumers alike

The yield from the new program to date had been very rich. For the administrative and program staff, there was a sense of movement, visible patient accomplishments, a new elan in staff-staff, staff-patient, and patient-patient relations. For the majority of the institution participants, life had indeed become better. The problem was how to increase yield for those not yet involved in the new program.

Change Consultation: Participant Feedback

When posed with the question "Do you believe that this type of consultation has had any value, made any difference, in implementing your hospital-side milieu program?", Oakville staff pinpointed the following types of assistance they believed it had provided:

- **reinforcement value,** an outside stimulus providing direction and support.
- **planning direction,** the necessity of formulating goals and objectives bringing about a more systematic and organized approach to change.
- **altered group process,** the need to conceptualize the "process of change" as we had realigned group relations on a more functionally oriented axis.

When asked what the "surprises" were in the process of implementing change, the group countered with "the time it takes," "the extreme value of goals," "the million details to attend in doing it," and finally "the real

wonder, real gratification, regarding the hospitalwide staff commitment" that had been evoked.

SUMMARY

A method has been proposed and illustrated for organizational change consultation that involves the evaluator serving as an organizational change consultant once the production of evaluation findings has occurred. This method of consultation is derived from the A VICTORY model of change, and proceeds in four stages subsequent to the application of the Readiness for Change scale presented at the beginning of this book.

The four stages in the application of the A VICTORY model as a guide to organizational consultation and change involve: first, *problem assessment* (i.e., what are prospects and problems involved in implementing evaluation findings?); second, *goal definition* (i.e., what does the organization want to achieve in concrete terms?); third, *action* (what are the necessary steps to take to bring about the change?) and fourth, *follow-through* (i.e., what were the consequences and what remains to be done?). In terms of the consequences of planned change, further needed changes emerge, and in cybernetic terms, the job is never done!

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