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**IMPLEMENTATION OF CONTINUOUS QUALITY IMPROVEMENT
IN A COMMUNITY MENTAL HEALTH CENTER: EFFECT ON MORALE**

by

Gary Dean Zomalt

**A dissertation submitted in partial fulfillment
of the requirements for the degree of**

**Doctor of Education
Leadership Studies**

University of San Diego

1997

Dissertation Committee

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ABSTRACT

IMPLEMENTATION OF CONTINUOUS QUALITY IMPROVEMENT IN A COMMUNITY MENTAL HEALTH CENTER: EFFECT ON MORALE

ZOMALT, GARY DEAN Ed.D. University of San Diego, April 1997. 292 pp.

Director: Susan M. Zgliczynski, Ph.D.

Morale is important to all service organizations because quality is dependent upon the nature of face-to-face interactions. Because the workers in mental health service organizations must care for patients, morale is especially important. Although studies suggest that rapid change due to cutbacks, privatization, and managed care, have demoralized mental health workers, the literature suggests that management is the problem. Mechanistic organizations with top-down, command-control management typically exclude and alienate workers. Continuous quality improvement (CQI) can improve morale as well as the bottom-line. However, there are no studies of how to implement CQI, from the perspective of workers, to improve morale in a private-sector community mental health program. This qualitative case study documents, from the perspective of workers, how a self-directed team implemented CQI to improve morale.

Results reveal that CQI was successfully used to assess and increase morale. Moreover, the workers opted to improve patient care over pursuing a pay raise. In the end, morale returned to normal because the team did not obtain the

training, the guidance, or the administrative support necessary to fully understand CQI, adequately use the quality tools, or get buy-in from management.

The results highlight the fact that in order to transform the organization and sustain morale, self-directed teams must collaborate with management to obtain consultation and training necessary for the long-term success of CQI efforts.

How to bring about that collaboration is the question. The researcher recommends starting by providing all CQI participants training in collaborative leadership. This would provide workers and management with an alternative, non-hierarchical model for implementing change.

DEDICATION

I dedicate this dissertation to my wife, parents, family, friends, and the community. I have learned that getting what one prays for is just the beginning. Asking for a blessing is easy when compared to the work required to make it bear fruit.

ACKNOWLEDGEMENTS

All glory belongs to God. The University of San Diego Leadership Studies Program has provided me with the educational experience necessary to integrate what I know and feel into a framework for understanding, promoting, and participating in the twenty-first century paradigm of leadership. I acknowledge all who have given me support and helped me complete this degree. I thank my Dissertation committee, Dr. Susan Zgliczynski, Dr. Lloyd Beckwith, and Dr. Ronn Johnson. I owe a debt of gratitude to my mentors and internship supervisors Joan Friedenberg, Steve Harmon, Harold Mavritte, Collins Munns, and Joseph Rost. I could not have completed this program without the participation of the staff at Project Enable, or support of Nikki Archer, Frances Hill, and Dr. Howard Carey. And, of course, a special thanks to my beautiful wife Meridith who was always there for me.

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CHAPTER 1: STATEMENT OF THE ISSUE

Introduction

Not since the industrial revolution of the late nineteenth century has society seen such dramatic change in both the workplace and within the workforce (Benge & Hickey, 1984). Heavy industry of the post-Civil War era dominated the United States economy for nearly a hundred years. The advent of the microchip jettisoned the nation from the industry-based to what is commonly referred to as the "information and service-based society" (Jensen, 1996; Walker, 1996). Consequently, the workplace has shifted largely, in the last few decades, from the factory to the service organization. Therefore, the industrial workforce has changed, predominantly, to service personnel. Berry and Parasuraman (1992) suggest a radical change in the way America's service organizations do business, because quality in service organizations is now dependent upon interactions between the worker and the customer. The workplace of concern in this study is community mental health organizations, and the workforce encompasses the employees responsible for delivering mental health services.

Of essence in mental health, as well as any other service organization, is the quality of the service. High quality in service organizations requires satisfactory interactions on a one-to-one basis between the provider and receiver of services. The fact that high quality is being threatened by changes that lower morale

forms the backdrop of this study. Changes in mental health care have affected morale, and it has been suggested that quality of service is greatly affected by low employee morale (Senge, 1991; Brown, Hitchcock, & Willard, 1994). How to improve morale and the quality of care in the face of rapid organizational change is the question.

Cutbacks, Privatization, and Managed Care

The conservative Reagan administration never appropriated funding for comprehensive mental health legislation enacted by the liberal Carter administration (Williams & Torrens, 1993). This marked the beginning of financial cutbacks and degovernmentalization; specifically, the privatization of government operated mental health services throughout the United States (Dorwart & Epstein, 1993).

Budget reductions in health and social services fueled the imperative to cut programs and to increase the purchase of mental health services from the private sector through managed care arrangements (Motenko et al., 1995). The espoused goal of privatization and managed care is to lower costs and increase the quality of care through market competition (Dorwart & Epstein, 1993; Osborne & Gabler, 1992; Williams, 1993). However, the demoralizing effects of cutbacks, privatization, and managed care on employee morale such as that experienced in Massachusetts (Motenko et al., 1995), has lead to concerns that similar effects could occur in San Diego County Mental Health Services. There are concerns among stakeholders in San Diego County because morale is crucial to the quality of patient care. In an era of diminishing resources, managed care seems inevitable. The evolution of privatized, managed mental health care locally mirrors

the rapid change taking place throughout the country. However, the problem is not as simple as managed care. Essentially, the problem is that it is difficult to grasp that a new age is upon us. We have entered what postmodernists call the postindustrial era. The post-industrial era is characterized by a change from a "goods-producing economy to a service economy" (Walker, 1996). According to Walker, what differentiates the postmodern society from the industrial society is primarily a change in the role of management. The change is essentially from that of the coordination of both machines and workers, to that of gathering, processing, and communicating information as a basis for change. Not grasping these important changes in the new era, traditional management has continued to attempt to cope with today's organizational challenges with yesterday's solutions. Dobyns and Crawford-Mason (1994) observed this trend and offered the following analysis:

Since 1775, when James Watt built a working model of his steam engine, we have lived in the Age of Machines, and those machines have been particularly good to us. Without them, we would not live nearly as well as we do. To continue to live well, however, we have to move beyond the machines to a new age. . . . We call it the Age of Continual Improvement. . . . What you call the new society or precisely how you describe its details is not as important as recognizing that what we have known and done in the past is not what we will have to know and do in the future. (p. 28-29)

According to Deming (1982), eighty-five percent of the problems experienced in organizations are attributable to management. In the past, we have been very

successful using a style of management that is mechanistic: that is, a top-down, command-and-control approach to management. As Dobyns and Crawford-Mason (1994) pointed out in their analysis above, the mechanistic approach has served the industrial-based society well. However, today, top-down, command-and-control management, no matter how impressive, will no longer guarantee success. Brown et al. (1994) underscore the fact that learning organizations are needed to cope with today's organizational challenges: "Today, the advantage comes from being able to out 'learn' the competition; to improve and learn continuously. This age, then, might more accurately be called the age of the 'learning organization'" (p. 214).

Peter M. Senge explains that learning organizations are "organizations where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning how to learn together" (1990, p. 1).

Society needs learning organizations, because today's organizations face rapid and continuous change. According to Morgan (1986), it is difficult, if not impossible, for the mechanistic organization to adapt to rapid change. To be successful, organizations operating in a rapidly changing environment require the use of collective intelligence and collective learning (Dixon, 1995). Therefore, mechanistic organizations must be transformed into learning organizations if they are to produce the level of quality that the information and service-based society demands. How to develop learning organizations is the question? We know that

to develop a learning organization, and the concomitant level of quality, is not a one shot deal. It requires continuous quality improvement, the hallmark of the learning organization (Brown et al., 1994; Dixon, 1995; Hiam, 1992; Senge, 1991).

As an essential component of the learning organization, continuous quality improvement (CQI) creates continuous change rather than reactive episodic adaptation to change (Dixon, 1995). Reactive or defensive change efforts are like summer rainfall on a desert. Such episodic infusions of quality quickly dissipate in the mechanistic organization (Hiam, 1992). The CQI process in learning organizations incorporates "planned obsolescence." Planned obsolescence is a concept developed by Raymond Lowrie. It means being inventive and innovative in order to continually offer the customer newer, more attractive goods or services (Crosby, 1979).

The thesis that contemporary organizational problems stem from the mechanistic form of organization is powerful. Consequently, contemporary organizational theorists often argue that the long-term threat to quality in service organizations is less associated with changes such as cutbacks, privatization, and managed care than it is to our mechanistic concept of organization. The mechanistic view of organization can constitute the single greatest threat to morale (DeWitt, 1980; Morgan, 1986).

Cutbacks and other changes are naturally destabilizing, but the mechanistic view of organization and its deleterious effect on morale is the quintessential challenge for the twenty first-century mental health service organization. Again,

cutbacks, privatization, and managed care are unquestionably factors in both the morale and the quality equation. However, outcomes such as morale and quality are largely dependent upon specifically how cutbacks, privatization, and managed care are implemented. In other words, outcomes are highly dependent upon the methods used to achieve them. In short, the management structures in which cutbacks, privatization, and managed care take place influence the impact of such changes.

Many blame changes such as cutbacks, privatization, and managed care for demoralization and the diminished quality (Motenko et al., 1995). However, organizational theory suggests instead, that the real threat to quality lies between our ears. The reason that the real threat lies between our ears is because the world has changed, but our mechanistic view of organization has not. The bottom line is that future organizations must depend upon their workers as much, or more, than management to improve morale and the quality of services. Therefore, concerning morale and the quality of services, the question is how to change our view of organization-as-machine; not how to stop managed care.

The Quality Movement

An estimated \$225 billion to \$360 billion could have been saved in the United States in 1993 through continuous quality improvement. Yet, no one prominent in the health care reform debate pointed out that quality improvement could solve the problem. This is despite our knowledge of how Japan transformed its traditional, mechanistic, command-and-control organizations through CQI after World War II (Dobyns & Crawford-Mason, 1991). Parenthetically, I prefer and use con-

tinuous quality improvement (CQI), a term used by health care practitioners in higher education (Marchese, 1993), to the term total quality management.

Many credit W. Edwards Deming with Japan's successful transformation through CQI. According to Senge (1990), from the outset, Deming's goal was to help the Japanese create what Senge calls learning organizations through CQI. Moreover, many American managers have tried to emulate Deming's success in Japan by implementing CQI. However, Senge found continuous quality improvement efforts in the United States lacking in their ability to create learning organizations. In his words:

Despite serious efforts by many [American] companies in the past decade, by and large we are back where the Japanese were in the 50's and 60's, focusing on bringing statistical process improvement to understand, measure, and improve physical processes. . . . But we are missing the deeper levels of total quality management, what pioneer Ishikawa once called the "thought revolution." (1991, p. 2)

Even though CQI techniques have been employed by managers as a means of adapting to the new age, "few [American] organizations have made the connection between creating learning organizations and total quality [CQI]" (Brown et al., 1994, p. 214). One might ask: how could this be? The answer is substantially that American organizations have left the workers out of the CQI process. Conversely, over the past 40 years, Japanese organizations have reportedly evolved into collaborative relationship with their workers. These learning organizations merge thinking and acting at all levels within the organization (Senge,

1992). Learning organizations are structured to include employees in quality improvement decisions, thereby addressing the employee's higher order needs (Senge, 1991). American managers would make the connection between CQI and learning organizations if they understood this simple axiom: "The first step for increasing quality is to find out what is on the workers' minds. If you can uncover workers' opinions of their supervisors, working conditions, and their job, then you can take action that will improve quality" (Benge & Hickey, 1984, p. 6).

Increasingly, CQI has been adapted to various health care settings to improve quality and lower costs (Cesta, 1993). Unfortunately, most studies of CQI efforts in health care are like that conducted by Allen and Josephson (1995). Mainly, the studies of CQI in health care ignore employee morale and focus exclusively on measuring patient outcomes.

Exceedingly, using CQI to achieve and measure patient outcomes has become popular in health care. Patient outcomes are important; but, it is doubtful whether the patient outcomes movement will get us to where we want to go with regard to quality (Epstein, 1993). While acknowledging the importance of patient outcomes, Sheil (1993) argues that it has been a mistake to focus exclusively upon patient outcomes. Focusing exclusively on patient outcomes is analogous to the automobile industry of the 1950s. At that time, the standard was to inspect automobiles after they reached the end of the production line. This process allowed inferior quality automobiles to be sold to customers. Consideration of employee-related outcomes is as important as end-use customer outcomes in CQI.

Continuous quality improvement is generally understood as a process that seeks to prevent defects by continually improving the quality of organizational systems, processes, and services through customer satisfaction (Bemowski, 1992). In addition, it is a method of achieving and measuring outcomes. But what is probably more essential, more problematic, and less understood is that customers, both internal and external, are equally important for CQI (Adair-Heely, 1991). In mental health for example, the employee, a provider of mental health services is an important internal customer; and, the patient, a receiver of mental health services, is an important external customer.

Officials, scholars, researchers, and practitioners alike are aware that, in theory, CQI improves and maintains quality through a continuous process that focuses on the satisfaction of both the internal and external customer. Moreover, it is generally agreed that unless workers buy into CQI, long-term success does not occur. Yet, amazingly, the preponderance of CQI research has been on the external customer only (Hunt, 1992). Wilson and Durant (1994) warn that the costs of implementing CQI are substantial. Therefore, prudence requires that CQI interventions be undertaken carefully. Consequently, if organizations are to maximize their CQI efforts, they will need more information about the needs and perspectives of the internal customer—the workers.

Outcomes

As previously stated, outcomes are important. In fact, CQI may be operationally defined by the outcomes an organization strives for and the major activities its people seek to create or enhance (Glazer, 1994, p. 15). In mental health, as

in any other service, outcomes may be defined in terms of whatever results that matter most to customers and the organization (Benveniste, 1994; Vermillion & Pfeiffer, 1993). Because quality in the service organization is tied to employee morale, one of the most important outcomes for the twenty-first century mental health organization is employee morale. Hence, we must learn more about how to satisfy the employees in mental health services in order to improve the quality of patient care. Brown et al. (1994) wrote: "This approach is called 'the [external] customer comes second'. . . . To delight customers with exceptional products and services, the employee is the first customer the organization has to satisfy" (p. 95).

McLeod (1991), Glazer (1994), and others have written that the implementation of CQI improved morale in educational settings. Although there are morale problems in mental health (Motenko et al., 1995), authors who have written about the implementation of CQI in mental health (Ray, 1993; Rago & Reid, 1991) do not address employee morale. Generally, the mental health literature is silent about the use of CQI to improve morale in community mental health organizations.

Nevertheless, there is a body of literature that suggests that one way to increase morale is to train and empower workers to recognize problems and to propose solutions (Smith, 1988). The genius of Deming's statistical process control was that it taught Japanese workers to identify defects and correct problems caused by faulty processes. Deming's CQI and Ishikawa's quality circles (an employee involvement approach wherein groups of workers get together and

identify problems and propose solutions) put the Japanese over-the-top in the quality race. Brown et al. (1994) found that there are differences between the top-down approach to CQI and the employee involvement approach to CQI. When compared, the outcomes of employee involvement CQI approaches are better than the outcomes of top-down CQI. They found that CQI approaches that use self-directed teams show significant improvement over the mechanistic approach.

Deming's CQI philosophy and techniques implemented through Ishikawa's quality circles empowered Japanese employees by giving them high degrees of autonomy. Lawler et al. (1992) also found that giving small groups of people high amounts of autonomy and direct access to customer demands often increases responsiveness and fosters innovation. More important, their study found that employee involvement may be superior where the work is primarily creative and the organization faces rapid change. Therefore, if American service organizations are seeking to duplicate the success of Japan, CQI efforts should encourage the workers to participate in the vision and the decisions of the organization. Only when workers collaborate in the CQI effort, can CQI transform an organization into a learning entity which is able to adapt and cope with the vicissitudes of the information and service-age (Morgan, 1986).

Manufacturers have made great strides in the quality race by implementing CQI with the goal of increasing employee involvement, but service organizations are not moving fast enough (Oberle, 1990). The literature suggests that the implementation of CQI can build learning organizations that facilitate the assess-

ment, the improvement, and the maintenance of morale and other important customer outcomes (Senge, 1991). Dobyns and Crawford-Mason (1991) wrote that "TQM [CQI] is a management technique whose time has come" (p. 1). We know that CQI has had mixed results. Brown et al. (1994) place the odds of an organization successfully implementing CQI at "two to one—against" (p. 24). Yet, CQI as a method of improving quality has gained worldwide acceptance. Because morale is such a crucial factor to quality in service organizations, better understanding of how to effectively implement CQI should become the number-one priority for mental health service organizations.

Despite the need, there are no studies that focus specifically on the mental health worker's perceptions and concerns about CQI, or how specifically to implement CQI to assess, improve, and maintain morale in community mental health organizations. Consequently, there is a special need for research, from the perspective of the workers, on how workers use the implementation of CQI in community mental health organizations to address morale.

While there are qualitative studies from the perspective of workers that describe the negative impact of cutbacks, privatization, and managed care, there are no studies of the impact of the implementation of CQI on the worker's morale in a private-sector community mental health center. Such a study should help determine the usefulness of CQI to assess, improve, and maintain employee morale. Successful change in mental health might ensue: if all participants understood the fundamentals of implementing CQI through the eyes of workers in a private-sector community mental health setting.

Purpose

This qualitative case study focuses on a frequently neglected human dimension of CQI—the worker. Achievement of sustained quality is impossible without enthusiastic worker participation. The literature suggests that low morale in service organizations negatively affect the workers, which, in turn, negatively affects the quality of services. Empowering employees through CQI to identify and propose solutions to work problems, can improve morale. This descriptive study documents the bottom-up implementation of CQI emphasizing the perspective of the workers in a community mental health program.

An exploratory case study of the implementation of a continuous quality improvement (CQI) process, and its impact on mental health staff morale, provides knowledge that was lacking. The purpose of this study is also to provide knowledge about the applicability of CQI with respect to the assessment, improvement, and maintenance of morale in a particular private-sector community mental health center. In the context of rapid change, it is essential to ascertain how workers in a private-sector community mental health center implement CQI, and to learn the impact on staff morale. Researcher observation, in-depth ethnographic interviews, focus groups, and anonymous surveys explored staff perceptions.

Research Questions

- 1 How is continuous quality improvement (CQI) implemented in a private-sector community mental health center?**

2. How do employees and the director perceive the specific experience of implementing continuous quality improvement (CQI)? The study will explore with workers and the director (a) what resources and training were needed, (b) what motivated workers to follow through or not follow through with specific processes, and (c) what were the problems associated with the study?
3. How is morale affected by the implementation of continuous quality improvement (CQI), as perceived by employees and the director?
4. How is quality of care, as perceived by employees and the director, affected by the implementation of continuous quality improvement (CQI)?
5. How much staff and director time does the implementation of continuous quality improvement (CQI) involve?

Definition of Terms

Continuous Quality Improvement (CQI)

For the purpose of this study, "CQI" is used synonymously with the term total quality management (TQM), a term used by Americans, and total quality control, a term used by Japanese (Bowles & Hammond, 1991). Continuous quality improvement is defined as the endless dedication to incremental and transformative improvement of organizational processes, services, and products. Continuous quality improvement is distinguished by its philosophical commitment to organizational learning, long-term success through customer satisfaction, and its use of quantitative and qualitative methodology to identify and to propose solutions to problems. Continuous quality improvement is based on the unique concept of the customer, which includes employees who regularly participate in organiza-

tional decisions by assessing, planning, and monitoring performance (Bemowski, 1992).

Customer (internal and external)

For CQI, the term "customer" is used in reference to both the internal customer (an employee or subunit who receives services, goods, and information, from within the organization), and the external customer (the recipient of services, goods, and information who is not part of the supplying organization (Bemowski, 1992, p. 22). The satisfaction of both the internal and the external customer is equally important.

Employee Morale

"Morale is the net result of the job satisfactions of the employees in a specified group, such as a department, a night shift, employees over fifty years of age, all female employees, or other groups" (Benge & Hickey, 1984, p. 10).

Guidance Team

The guidance team is composed of managers and other members selected, as needed, by the director of Project Enable. The guidance team provides support to the staff process action team's efforts, responds to the needs identified by staff process action team, and secures resources.

Managed Care

Managed care is a term associated with privatization. Managed care is the reliance on the market and on competition to reduce health care costs. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) are the most common type of managed care organizations (Dorwart, 1993). Un-

der managed care, "providers are usually paid a fixed fee for each person served without regard to the amount or the nature of services provided" (Dorwart & Epstein, 1993, p. 48).

Staff Process Action Team

The staff process action team is composed of the employees of the Project Enable, Day Rehabilitation program. This self-directed work group identifies problems and proposes solutions to the director, chair of the guidance team.

Assumptions and Limitations

At the time of this study, the researcher was a graduate student completing a dissertation, and, he was an employee of San Diego County Mental Health Services. San Diego County Mental Health Services contracts with Neighborhood House Association, Project Enable, the private-sector community mental health program in which this study took place. On the surface, the investigator appears to be an "insider." Indeed, there are benefits for the insider-researcher in terms of access, rapport, and the promise of professional prestige. However, Glesne and Peshkin (1992) caution against yielding to the temptation of doing research in one's own "backyard," because the hazards of role confusion, as well as ethical and political dilemmas, may outweigh any potential benefits received from backyard research.

In fact, the investigator was an outsider to the research group. The investigator had only three contacts with the Day Rehabilitation program in 9 1/2 years. Therefore, the researcher did not anticipate problems that are associated with doing research among colleagues, supervisors, and friends.

It was assumed that the researcher could gain the trust necessary for participants to allow him inside the group, while avoiding bias (such as over-identifying with research participants) associated with working closely with a group. Knowledge of ethnographic principles, methods, and techniques was assumed to be of value in the researcher's attempt at entering, maintaining rapport, keeping appropriate boundaries, and exiting the research group.

Gender is an important issue pertaining to assumptions. The influence of gender (as well as race, class, religion) in research where the researcher uses him or herself as the primary research instrument is significant. Silverman, as well as others, have documented the effects that gender has on how the participants act and what they report. As a psychotherapist, I am familiar with this phenomenon. I am also aware of how such issues arise and how appropriately to deal with them should any arise.

An obvious limitation by design is that the focus of this study is almost exclusively on the workers' perspective. Also, because the implementation of CQI can take up to five years, this study is only a snap-shot of the beginning of the CQI implementation process. Moreover, the findings of a single case study are quite limited and they cannot be generalized. This particular case study is non-random, and the participant population is not representative. Nonetheless, it has importance for its potential to reveal workers' and others' perceptions of the implementation of CQI and the resultant effect on morale in a community mental health center. Such a study has usefulness in its potential to increase our under-

standing of problems or puzzling occurrences arising in everyday practice (Merriam, 1988).

Another assumption is that the Motivation to Participate survey administered at the beginning, and the Employee Morale Assessment (EMA) survey, which was administered at the beginning and at the end of the study, cannot be interpreted from a quantitative perspective. This descriptive data will not allow inferences, but rather, will identify issues related to participants' motivation to participate, and issues related to participants' morale in the study. The descriptive numerical data generated by the EMA are intended to provide workers and others with a simple assessment of morale. The investigator is primarily interested in the validity, meaning, and importance that the workers attribute to the survey findings. It is also important to learn how they use the survey findings. Silverman (1993) has demonstrated the value of descriptive statistics, viz., simple tabulations to summarize the characteristics of data obtained by the researcher, and for validating impressions obtained from qualitative data. Any use of numerical data in this study is consistent with the purpose of descriptive statistics. Descriptive statistics are used "to describe things the way they are, rather than to investigate a cause-and-effect relationship" (Huck, Cormier, & Bounds, Jr., 1974).

This study further assumes that, as a concept, CQI presupposes an association between the satisfaction of the worker, the internal customer, and the satisfaction of the external customer. The relationship between the internal and ex-

ternal customer in mental health is particularly unique because the therapeutic relationship is based on the worker caring for the patient.

Finally, the researcher assumes that because the study asks questions about and shows concern for employee morale, it can cause changes to occur similar to those manifested in the Hawthorne studies. However, this fact does not detract from the purpose of this study, which is to understand the implementation of CQI and morale from the perspective of the employee.

CHAPTER 2: REVIEW OF THE LITERATURE

Introduction

High morale among workers is crucial to quality in service organizations (Senge, 1990). Mental health services are in a state of crisis due to antiquated management practices and increasing health care costs (Rodriguez, 1989). Management consultants, such as Osborne and Gabler (1992), argue that privatization of government programs create private-sector learning organizations that lower costs and are more responsive to customer needs. Dorwart and Epstein (1993) found historically that entrepreneurs have argued that government-operated programs are too bureaucratic, wasteful, and lack incentive to meet customer needs. Their belief is that private-sector organizations, driven by market forces, must respond to the needs of the customer.

Dorwart and Epstein (1993) conducted a national survey that refuted this belief. Their survey examined the influence of government versus private-sector ownership on organizational responsiveness to the needs of a diverse mental health population. They found no evidence that private organizations are inherently more innovative or inherently more adaptable than are government organizations. They concluded that in non-competitive circumstances, "government agencies will in fact be more innovative" (p. 89).

Comprehensive cost containment strategies have evolved to cope with spiraling health care costs and poor quality. Alternative service delivery systems, such as privatized-managed mental health care programs, with spending limits, have gained prominence among the latest cost cutting strategies. Although it appears that managed care can decrease costs, serious questions persist concerning morale and quality of care. The literature clearly documents the demoralizing effects of cutbacks, privatization, and managed care (Motenko et al., 1995). Hence, the challenge of how to cut costs, raise morale, and improve the quality of care has become the paramount challenge. The literature on organizational theory suggests that poor morale and poor quality are caused by out-dated views of management and organization (DeWitt, 1980).

In fact, the literature suggests that mechanistic views of management and organization are destructive in rapidly changing environments. However, several underlying cultural assumptions perpetuate the mechanistic view of management. Americans view management as an entity headed by a strong, autocratic, charismatic man who commands and controls the people under him. This cultural narrative implies that management skills are innate; therefore, the manager is entitled to receive a higher salary, and to benevolently dictate what must be done and when. Greenleaf (1977) believes that this hierarchical view of management "is deep in our traditional wisdom, at least as old as the story of Moses" (p. 83).

The mechanistic view has been challenged; though not with much success. The mechanistic view of organization as command-and-control remains domi-

nant, even though it has been highly associated with low morale among workers (Morgan, 1986). More than ever before, organizations are finding it necessary to change. Apropos, Dixon (1995) wrote: "It is increasingly recognized today that as organizations face continuous change, they require the use of their collective intelligence" (p. 1). Mechanistic organizations are dysfunctional because they depend on the intelligence of a few at the top. Consequently, there is recognition of the need to evolve new forms of management practices based upon a different view of organization.

Because of the critical role morale plays in the performance of and the quality produced by the service organization, managers must address employee needs. Workers empowered through CQI can collaborate with managers to create learning organizations that invent and innovate ways to delight customers. However, largely, this has not happened. Senge 1990 wrote:

I believe the quality movement as we have known it up to now [in the United States] is in fact the first wave in building learning organizations—organizations that continually expand their ability to shape their future.

The roots of the quality movement lie in assumptions about people, organizations, and management that have one unifying theme: to make continual learning a way of organizational life, especially improving the performance of the organization as a total system. This can be only be achieved by breaking with the traditional command and control, hierarchy where the top thinks and the local acts; to merge thinking and acting at all levels. (1992, p. 2)

Learning organizations can be created through the implementation of continuous quality improvement (CQI) (Brown et al., 1994; Senge, 1991) because it utilizes the collective intelligence of everyone in the organization to address costs, morale, and quality. The problem is American managers have frequently ignored the workers' need to be included in the decisions. Deming, often dubbed the father of the quality movement, is said to have been:

Deeply frustrated with the inability of American management to grasp the deeper message of the worldwide quality movement. . . . The deeper transformation starts with distinguishing "intrinsic from extrinsic motivation" and developing an organization where everyone, from top to bottom, is a learner. (Senge, 1991, p. 2)

The main problem is that the CQI is a difficult process to implement. Success varies depending upon the context and the strategies employed. Studies have shown that the failure of America's CQI efforts is highly associated with the mechanistic management perspective which, does not include the worker in any meaningful way (Brown et al., 1994). This proclivity largely explains why there has been such disappointment with American CQI efforts. If mental health service organizations are to survive and thrive, they need to use CQI to create learning organizations that will improve morale and the quality of care. However, because American efforts have been dominated by the mechanistic view of organization, there is an important knowledge gap in the literature. To date, there has been no research on the implementation of CQI in community mental health programs emphasizing workers' participation or the workers' perceptions of the im-

portant issues related to morale. Therefore, studies of the implementation of CQI from the workers' perspective are needed to fill the knowledge gap.

This chapter discusses selected literature pertaining to concerns about managed care, then turns to the real problem—management. Following is a review of organizational theory literature, which discusses metaphors and mental models of organization. These deeply held views of organization shape our behavior. Next, a discussion of CQI theory covers the topics of life-long learning, the quality gurus, and using the CQI model. Finally, a review of the literature pertaining to CQI in health care follows a selected review of job satisfaction literature.

Concerns about Managed Care

In 1995, officials decided to contract most of San Diego's county-operated mental health programs, and to convert its mental health system to managed care. A major concern about the decision for a managed care system was that quality of care may be adversely affected by job dissatisfaction associated with cutbacks, privatization, and managed care (Dumont, 1992). Advocates of the quality movement have tried to reassure critics of managed care that managed care can improve the quality of care. There has been progress in discussions about quality of care and morale in the mental health managed care debate. This is very encouraging because the issue of morale is critical to quality in service organizations. "Quality [in service organizations] is determined in individual transactions between 'servers' and customers, occurring literally thousands of times each day in large organizations. . . . It [quality] depends on how happy the

server is and on whether he or she experiences the job as satisfying" (Senge, 1990, p. 333).

Motenko et al. (1995) examined the effects of managed care on the therapeutic milieu in a case study of patient and workers' impressions of cutbacks, privatization, and managed care in the Massachusetts's mental health system.

They found that: "Services were cut so drastically, that the therapeutic milieu was lost. . . . Social workers are not just overworked by new agency policies; their work environments violate the basic tenets of professional ethics" (p. 461).

Williams and Torrens (1993) discussed the association between managed care and dissatisfaction among physicians. They found physicians were most disaffected by the fact that control over important treatment decisions was taken out of their hands by managed care. The study by Motenko et al. reported that social worker's morale was seriously impacted by managed care and that higher levels of burnout and job dissatisfaction were noted. "They were demoralized, but we did not expect the depth of demoralization we encountered" (1995, p. 461).

The issue of privatization and managed care is widely discussed, and many would like to see the system go back to the old way of doing business. However, there is no stopping cutbacks, privatization, and managed care. According to Dorwart and Epstein (1993), there is no turning back. Williams wrote, "the question of whether to support or to oppose managed care may be less salient than the issue of how best to shape and participate in the processes of managed care" (1993, p. 200). Improving employee morale is one of management's greatest challenges in creating and maintaining high quality, privatized-managed

mental health services in the twenty-first century. Issues of quality in the service organization span the continuum between how to cut costs and how to improve morale and the quality of services. Examining and evolving our view of organization is important to integrating cost cutting with improving morale and the quality of services in managed-mental health care organizations.

Organizational Theory

Senge (1990) believes that in learning organizations "increasing quality and lowering costs can go hand-in-hand, over time (p. 65). Nevertheless, he insists, the greatest impediments to adopting a new idea or a new approach "are the deeply held internal images of how the world works; images that limit us to familiar ways of thinking" (1990, p. 174).

Senge calls these images mental models. Mental models can be simple generalizations or complex theories. Mental models are systematized conceptualizations of reality that have a powerful affect on our attitudes and behavior. Like mental models, Garret Morgan (1986) believes that the use of metaphor can help us understand the nature of organization from a theoretical perspective. Understanding organization from the perspective of images inherent in metaphors is important, because the way we conceptualize and define reality is metaphorical (Lackoff & Johnson, 1980; Morgan, 1986).

The Mechanistic Organization

Morgan (1986) suggests that the metaphor of organization-as-machine best captures the current view of reality and describes the industrial-era form of organization. The mechanistic organization is traditional in the sense that its man-

agement structure is top down and command-and-control oriented. The mechanistic manager will typically exclude employees from organizational decisions and policy-making processes affecting quality. According to Morgan, the mechanistic metaphor was canonized in Fredrick Winslow Taylor's Principles of Scientific Management, published in 1911. Dobyns and Crawford-Mason (1994) wrote that Taylor's scientific management organized work so that a worker would do only one job exactly as she or he is told, with no deviation, no innovation, and lots of supervision.

Dobyns and Crawford-Mason (1994) point out that by today's standards, the mechanistic view of organizing is antiquated, and, "if we are to survive [and thrive] American managers must change what they think and believe" (p. 4). "In [industrial-era] quality manufacturing, the boss had to know it all and had to command and control the workforce" (p. 23). Mental health as well as other organizations must discard this Taylorian notion of management's role in organizations if it is to successfully meet the challenges of rapid change.

The Japanese discarded Taylor's idea long ago (Dobyns & Crawford-Mason, 1991). Nevertheless, the majority of American managers are still operating out of the machine mind-set. Managers want to change, but the machine metaphor is so ingrained that it is second nature in everyday thinking about management and organization. "The principle of separating the planning and design of work from its execution is often seen as the most pernicious and far reaching element of Taylor's approach to management, for it effectively 'splits' the worker, advocating the separation of hand and brain" (Morgan, 1986, p. 32).

Berry (1991) declared that: "TQM [CQI] is a management system whose time has come" (p. 1). To make CQI a reality, organizations must change their mechanistic management system. It must be changed because it tends to breed anger, alienation, and apathy among the workers at the bottom of the organizational hierarchy; thereby lowering productivity (Odiome, 1991).

When faced with change, which is usually perceived as a problem, mechanistic managers tighten control and rely on rewards and punishments to motivate workers. Managers should keep in mind, that as United States citizens, the American service worker has a highly developed sense of entitlement to human rights. Moreover, they are neither motivated nor satisfied with just earning a pay check. Today's worker wants to feel valued, creative, and fulfilled. Most of all, they want to feel that they are part of a community (Holden, 1990). Benge and Hickey (1984) and others have written about how manager's antiquated beliefs about workers affect job satisfaction and productivity. The mechanistic manager typically does not agree with the idea of addressing worker's needs in the workplace. But in fact, once managers respond to the workers' need to get involved increased morale and productivity will follow (Harris, 1989). Today, management's job is to unite workers toward the common goal of using CQI to transform the organization into a learning organization.

The Organization-as-Brain Metaphor

The concept of a learning organization is best understood as a metaphor of organization-as-brain. Below, Morgan describes a learning organization:

The whole ethos of plant operations is characterized by holographic integration. The work design was stimulated by the desire to create a holistic relationship between people and their work, so that employees would acquire a sense of identity with the firm and its products. . . . The results have been spectacularly successful, improving productivity, quality, innovation, and work life in almost every aspect. (1986, p. 104)

In the conclusion of this chapter in his book on the brain metaphor, Morgan summarized what theories of organizational learning and capacities for self-organizing suggest: "In particular, they suggest that innovative organizations must be designed as learning systems that place primary emphasis on being open to inquiry and self criticism" (p. 105).

Implementing continuous quality improvement is one way to build learning organizations (Brown et al., 1994; Senge, 1991). It is a process wherein the system is continually scrutinized; the entire organization is united toward the endless pursuit of improvement, invention, and innovation. In an organization based upon the principles of continuous quality improvement, "You can never say, 'we are a learning organization,' anymore than you can say, 'I am an enlightened person.'" (Senge, 1990, P. 11).

Continuous Quality Improvement Theory

In order to improve services continuously, personnel in the twenty-first century organization must become life-long learners. This is a necessity for the organization to compete in the information and service-age economy. Consequently, "adult development is an idea whose time [also] has come" (Dobyns &

Crawford-Mason, 1991, p. 35). The fact that society calls for an educated workforce that continuously develops is a relatively new phenomenon (Dobyns & Crawford-Mason, 1991). Consequently, organizations are searching for ways to foster the adult development that today's complex society calls for (Levinson, 1990). According to Levinson, we only conceptualized the first twenty-years of human life as development in the past. After age twenty, the process was called aging. We now know that development and learning is a life-long process.

Implementing CQI is a way of structuring adult development and building learning organizations. The primary goal of the learning organization is to teach people to learn how to learn together (Senge, 1990). This means the group; not the individual, is the focus of attention. This concept is foreign to American culture. Individualism, another important industrial-era American value, is an underlying factor that has made it difficult to create learning organizations using CQI in the United States.

The term learning in America usually conjures up images of people competing for the right answer or the highest grade. Often learning means individuals passively accepting knowledge provided by an expert (Brown et al., 1994). In other contexts, learning invokes the image of individuals using knowledge as status. Often individuals who treat knowledge as status hurl ideas at each other on a given topic in what appear winner-takes-all contests. These competitive interactions proceed from discussion, to concussion, to percussion (Senge, 1990). Radical change in our views about learning is needed. Old notions that value individual learning must be discarded. Today and in the future: "Team learning is

vital because teams, not individuals, are the fundamental learning unit in modern organizations" (Senge, 1990, p. 10).

Implementing Continuous Quality Improvement

Pollit and Buckaert (1995) said about the use of the word "total" in total quality management: "If a concept includes everything, it means nothing" (p. 5). Senge (1990) acknowledges that building learning organizations is largely unexplored. More important, though CQI can build learning organizations, little agreement exists on the definition of CQI because a wide variation exists in the content, scope, and formality of processes in existence today (Glazer, 1994). Dobyns and Crawford-Mason (1994) wrote:

American managers at all levels and in all fields do not know how to manage in this new global economy. . . . There is little public understanding of the need for quality management, little appreciation of what quality management could do for us, and little agreement on what quality management is. . . .

Change is required—dramatic change. Adopting the quality system of Dr.

Deming requires a personal change so radical that Deming called it transformation, a change of state from water to ice. (pp. 51-52)

Though Deming spoke of radical change, he did not leave one-size-fits all blueprints.

Brown et al. (1994) place the odds of successfully implementing CQI at two to one—against. They estimate that between one-half and three quarters of all organizations drop their CQI efforts within the first two years. Therefore, one may deduce that widespread knowledge of how to implement CQI is apparently lack-

ing among the majority of American managers. Yet, multitudes have written about CQI. Chief among those who have written about CQI are Philip B. Crosby (1984), W. Edwards Deming (1982), and Joseph M. Juran (1988). All are considered authorities on CQI, and all espouse certain common principles that can guide us. One of the most important principles is the belief that the employee closest to the job has valuable experience and knowledge vital to the development of the best solutions to organizational problems (Herman, 1989). Of the above three quality experts, Deming who died in 1994, and Juran are icons to the Japanese because of the contributions they made to Japan's post-World War II economic recovery. Crosby is the most popular among American executives of the three, because he is a former corporate executive, and because of his polished "quality is easy" philosophy.

Dobyns and Crawford-Mason (1991) wrote, "each of the four [referring to Crosby, Deming, Juran, and Feigenbaum] thinks the other three are not quite right" (p. 53). There are some important differences among the three and each advocates a different approach to achieving quality. While Deming's first love was statistical process control, he was very committed to a uniquely revolutionary quality management philosophy. He emphasized the necessity for transformational change in management in order to bring quality into manufacturing and service organizations. He emphasized how difficult and time consuming it is to achieve the level of change required to become a quality organization. Deming is also noted for saying that workers have the right to enjoy their work. Deming criticized "management by objective" (Dobyns & Crawford-Mason, 1994, p. 74),

a concept developed by Peter Drucker (Crosby, 1989). He taught that quality makes profits.

Crosby in contrast, is more technically oriented. In his book, Quality Without Tears, for example, he tells managers in a simple straight forward manner how to easily foster quality in their organizations. He endorses management by objective, which is compatible with his model. Crosby believes, as did Deming, that management is the problem and “cost reduction is a by-product of quality improvement” (p. 140). He also advocates zero defects. Deming believed that an organization can never achieve zero defects because of variation inherent in all systems.

Juran does not believe that quality is as difficult to achieve as Deming thinks, or as easy to achieve as Crosby portrays. He teaches that managing for quality is like managing for finance. Juran does not believe statistical method is as important as Deming does. Finally, Juran does not view competition as bad; whereas Deming teaches that competition within an organization is disastrous. Deming disagreed with Juran and he taught that cooperation within an organization was necessary to compete with outside organizations. All three of the above quality experts have developed comprehensive models that include their ideas about what CQI is and what principles are important to understand. None of the three provides details about how exactly to implement CQI in a community mental health organization from the workers perspective. Consequently, one must decide on which of the three models or combination of these models is best suited to one's specific needs.

This dissertation reflects many elements of Deming's philosophy about CQI. Deming's model is, in my view, the best management philosophy because it integrates continuous quality methodology to build learning organizations. Deming distinguishes himself more than any other of the quality gurus, in his demand for management to change. He asks managers to transform their organizational culture in order to build in the quality ethic (Dobyns & Crawford-Mason, 1991). His philosophy, more than any other, requires changes in the relationship between management and workers in order to involve everyone in the organization. As you will see, Deming's philosophy is far from being a blueprint for this dissertation. Following are the important principles adopted from Deming. Foremost, he taught that the traditional organization does not fit in the future.

There are fourteen points and seven deadly diseases in Deming's model (Walton, 1986; Appendix A). The fourteen points are the essence of Deming's model. Parenthetically, Deming did not teach the fourteen points and seven deadly diseases to the post-World War II Japanese. He developed them thirty years later from experience working with Japanese and American organizations.

There are three key principles among many in Deming's model: constancy of purpose, continual improvement, and profound knowledge (Dobyns & Crawford-Mason, 1991). Constancy of purpose requires that everyone in the company know what business they are in and act collectively to learn and grow in that business. The essential ingredients in constancy of purpose are collective vision and purpose. Continual improvement simply means that the organization collectively engages in a process whereby groups and individuals incessantly seek

ways to improve services. The important ingredients in continual improvement are continuous process improvement, invention, and innovation.

Profound knowledge, a term Deming did not define until 1988, is not one of the fourteen points. It is an overarching systems perspective and ethic required for successful continuous quality improvement. Profound knowledge consists of several inseparable principles. The broad categories are: systems theory, theory of variation, theory of knowledge, and theory of psychology (Dobyns & Crawford-Mason, 1991).

Deming stressed system thinking. Dobyns and Crawford-Mason (1994) characterize his philosophy as a system of thinking about systems (p. 35). Systems theory according to Deming requires the elimination of internal competition. Having done so, people in the organization are more likely to achieve their mutual purpose. What is critical about any system is how to manage that system. Traditional management cannot and does not get the best from any system (Dobyns & Crawford-Mason, 1994, p. 38). Systems thinking promotes the common good.

People have problems grasping the theory of variation. It simply teaches the difference between random variation, and special causes of variation caused by problems in the process. Random variation is typical and occurs in all systems. Random variations normally do not require intervention. On the other hand, special variations need to be corrected. Statistical process control, a term associated with Deming's genius, is a method he taught along with other statistical

methods and quality tools to the Japanese workers to help them distinguish between a special versus a random variation.

Deming taught that knowledge is not absolute because we know so much that is not true. The theory of knowledge has several underlying principles. One is that definitions are required for theory to be of value. A second principle is that we cannot learn from experience without theory. Deming argues against imitating others unless one understands their theory (Dobyns & Crawford-Mason, 1991). Deming taught that what is true depends upon the theory and the method one uses to arrive at truth. Different theories highlight different facets of a given phenomenon. Deming's theory of knowledge is similar to Senge's mental models, and Morgan's metaphors in this regard. By focusing on one aspect to the exclusion of other aspects of the same phenomenon, theories highlight and hide equally important aspects of reality. For example, McGregor's (1960) "Theory X" and "Theory Y" gives us different answers to the same question about the nature of man. This brings us to the last principle, the knowledge of psychology.

Knowledge of psychology is one of the most important elements of profound knowledge because it explains what motivates people. The knowledge of psychology principle is consonant with McGregor's Theory Y. It states that people are intrinsically motivated. People are naturally curious and learn at different rates. In addition, the way in which people learn varies from person to person. Deming taught that Theory X behavior, which is based upon the notion of external, or extrinsic motivation such as rewards and punishments, destroys intrinsic motivation. Theory X assumptions are the foundation of the mechanistic model.

Theory Y assumptions are the foundation of Deming's model of CQI. Now that we understand the most important concepts taken from Deming's model, it would be helpful to understand more about the implementation of CQI from the perspective of what led to Japan's success.

Lessons from Japan's Success

It is nearly impossible to determine exactly who was the originator of the quality movement in Japan. Americans and Japanese like to credit Deming with initiating the quality movement that led to Japan's remarkable economic recovery after world war II. Many believe that Deming is the father of the quality movement and would date its inception at May 16, 1924. That was the day that Walter Shewhart, Deming's mentor, gave his boss a memorandum that contained a flow chart suggesting that the use of statistics could improve quality. Briefly, Deming first learned of the idea of using statistical process control from Shewhart (Walton, 1986) and later taught it to the Japanese. The "Deming Prizes" are the most coveted awards given to quality Japanese organizations. Nevertheless, there are those who disagree that Deming is responsible for the total quality revolution in Japan. Actually, Deming took offense at the term "total quality management." Senge (1992) quotes Deming as saying that, "[his] work is about a transformation in management and about the profound knowledge needed for transformation. Total quality stops people from thinking" (p. 1).

Bowles and Hammond (1991) wrote that crediting Deming and other American gurus with planting the seeds of quality in the 1940s and 1950s is appropriate. As for crediting Deming and other American gurus with Japan's economic

success, they wrote: "But for the most part this is a modern version of Tom Sawyer whitewashing the fence. Virtually all of the most important innovations in continuous improvement—kaizen—were made in Japan" (p. 28). Kaizen (pronounced ky'zen) is a very important term in the Japanese culture. Masaaki Imai (1986) defines kaizen as . . . "continuing improvement in personal life, home life, social life, and working life. When applied to the workplace kaizen means continuing improvement involving everyone "(p. xx).

Bowles and Hammond (1991) credit Taiichi Ohno and Kaoru Ishikawa for breathing the life into the quality movement in Japan and in America. In Chapter three of their book, Beyond Quality, Bowles and Hammond describe how Ohno discovered waste in a Ford plant he visited in Detroit:

The system was particularly wasteful in its use and deployment of people.

The Ford approach assumed that workers would perform one or two simple tasks over and over. . . . None of the workers beyond the line worker was adding value to the product. (p. 30)

Bowles and Hammond believe that Taiichi Ohno gave birth to the modern idea of continuous quality improvement. They say Ohno's insight led to the distinct Japanese practice of setting aside time for workers to meet with quality engineers, and among themselves, to discuss ways to improve the production process. In addition, his experimentation with worker involvement ultimately led to the widespread use of "quality circles" in Japan. Dobyns and Crawford-Mason (1994) give Kaoru Ishikawa the Lion's share of the credit for the quality revolution because he institutionalized quality circles in Japan. Quality circles are groups of

Japanese employees who voluntarily meet to identify problems and propose solutions. Japanese management is known to spend an entire day listening to proposals from quality circles (p. 30). Quality circles are an essential component in the Japanese CQI method. Regarding quality circles, Dobyns and Crawford-Mason (1991) quote Robert E. Cole in their book, Quality or Else:

No American in the 1950s was talking about quality improvement as a participative system of management that involved all employees and all departments. This was a Japanese innovation. . . . Active worker participation is the key to any successful total quality program. (103)

The fact that there are at least two views about whom started the quality movement illustrates Deming's point about the importance of theory of Knowledge. Depending on one's theory, either Deming who taught the Japanese statistical process control, or Ohno who institutionalized the involvement of workers in the quality improvement process is the father of the modern quality movement. The truth is that both have made significant contributions as well as others. This debate underscores the fact that many contributed to Japan's success. However, there is no blueprint for the implementation of CQI.

The lack of agreement on the originator of CQI and the lack of a specific blueprint to follow undoubtedly is part of the reason Senge (1992) has found quality efforts in the United States fragmented. However, he believes that the main reason for the fragmentation of CQI efforts in the United States is the traditional view of organization. He explains: "the best of our international competitors are not fragmenting, they are building—steadily advancing an approach to

improving quality, productivity, and profitability that differs fundamentally from the traditional authoritarian, mechanical management model" (p. 1).

Crosby (1979), also frustrated with the fact that American managers have not been able to duplicate the success of the Japanese, wrote: "There has been a lot of effort expended on quality, but not much has been achieved. . . . American managers went to Japan and came back with quality circles and statistics" (pp. 13-14). Not much has changed since Crosby wrote this statement back in 1979. Dobyns and Crawford-Mason (1994) believe that the main reason why quality circles did not work in the United States is because there is nothing in the mechanistic view of organizations that requires managers to listen to workers.

Although Deming was originally interested in statistics, he taught that a bed-rock philosophy that is compatible with statistics, was necessary. He realized early on that implementing statistical control processes alone to achieve quality would result in failure (Walton, 1986). In the same vein, Brown et al. (1994) wrote the following about American CQI efforts: "If there has been a failure, it is not one of philosophy; it is one of implementation" (1994, p. v). Dobyns and Crawford-Mason (1994) concluded: "The Americans who went to Japan had used analysis . . . They did not use synthesis, so they missed the whole, and in continual improvement, the whole is greater than the sum of its parts" (p. 36)

Utilizing the Continuous Quality Improvement Model

Although the CQI philosophy is composed of many consistent themes, implementation strategy varies depending upon any number of factors. Actual implementation of CQI requires movement from the philosophical to a strategic

framework for implementation. Organizations must make strategic choices about how, when, and where to start. "They typically start by attending a number of workshops on quality topics and institute quality workshops to test the applicability of CQI principles in their organization" (Brown et al., 1994, p. 1). Invariably, all CQI implementation strategies involve the use of one or more of the following committees: An "executive steering committee" which is usually composed of top management who provides the vision and mission statement, develops the CQI plan, publicizes the quality process plan, establishes a quality management board or quality council, allocates resources including resources for training, and implements a quality recognition program.

The quality "management board" established by the executive committee is usually composed of middle management, and is responsible for the implementation of the quality plan. This includes conducting surveys of the internal and external customers, establishing the employee suggestion system, identifying problems impacting quality, collecting and analyzing data relating to processes. Duties also include forming process action teams to study specific problems, suggesting solutions, implementing solutions, promoting team recognition, and reporting results to the executive steering committee.

The "process action teams" which are established by the management board are composed of workers. There are different types of process action teams (PATs) or quality improvement teams: Functional PATs are on-going. They work within one function or program to improve processes or solve problems in a specific area. Cross-functional PATs are composed of people from different

functions or programs to identify and solve a common problem. Formal task PATs solve specific problems identified by the quality management board. Informal task PATs are similar to quality circles. Employees usually form a PAT to identify problems and propose solutions. Informal task PATs inform management of problems and propose solutions. They also help to implement and track progress.

Scholtes et al. (1988) uses different names for committees involved in the implementation of the CQI process: The "guidance team" which is composed of three to six managers and other leaders with authority, supports the "project team's" efforts, secures resources, and clears the path in the organization. The guidance team identifies the project goals, prepares a mission statement, determines needed resources, selects the team leader, assigns the quality advisor, and selects the project team. The guidance team functions much in the same way as the quality management board. The guidance team selects the "team leader" to lead the project team, attend to logistical details, and facilitate meetings. The guidance team also selects the "quality advisor." The quality advisor is usually a person trained in the CQI approach and group process. The quality advisor also helps keep the team on track and provides training as needed.

The above committees operate within a larger CQI framework or approach. Brown et al. (1994) point out that there are several approaches to CQI implementation. Below, is a discussion of the advantages and disadvantages of two common approaches to a CQI implementation: the "standard" and the "fasttrack" approaches. The standard approach is probably the most popular. Typically, the

organization initiates the implementation of CQI by training employees and establishing quality improvement teams. Over a period of years, more detailed training on process re-engineering and benchmarking is offered. This is Phase I and can take five years or longer in many large organizations.

As Phase I nears completion, the organization further expands the impact of CQI. Usually, Phase II begins with an overall assessment of the organization's systems, processes, and results. Assessment findings are then translated into plans to design new systems and restructure existing processes and systems. This takes a minimum of two to four years.

Seven to 10 years after beginning Phase 1, a company using the standard CQI implementation approach moves into Phase III. Only when the organization reaches Phase III, does the CQI concepts of prevention and empowerment get integrated into day-to-day operations. Based upon the standard approach to implementation, CQI takes one year for every layer of management.

The fast-track approach is for organizations that do not want to spend 7 to 10 years to implement CQI. The organization initiates a multifaceted approach to deploy fully continuous quality improvement. This approach is initiated with an assessment of the organization's systems, processes, and results. This assessment is the basis for planning Phases I, II, and III. With the fast-track approach, Phases I, II, and III do not have to be implemented in sequence, and there is a great deal of overlap. For example, self-directed work teams may start in the second or third year of the implementation. This fast-track approach is

more risky than the standard approach. Changes are rapid and often significant, increasing the levels of stress on employees.

The fast-track approach also presents more risk because it requires that major investments be made over a period of 3- to 5-years, rather than the 10-year period common for the standard approach. Consequently, companies short on cash reserves may find it difficult to adopt this approach. Ironically, the companies most likely to choose the fast-track approach are those that are in the most trouble and that often have the least resources. With the fast-track approach, it will take a large organization about five years to reach the point where CQI is completely integrated into the organization. Small companies that use this approach should expect to spend at least three years.

The standard or the fast-track approaches may be implemented in conjunction with Seymour's (1993) "cascade" or "the trickle down" model, the "infection" or "bubble up" model, or "the loose-tight" model. The cascade model involves educating and training senior officers of an organization in continuous quality improvement principles. These officers then develop a vision and a plan for the organization that they pass down to division and unit officers. Officers also receive training in CQI, and subsequently implement the agreed upon CQI plan. Although this model creates movement and a sense of purpose, its weakness is that it suggests that there is a right way to do things, which is counter to CQI philosophy.

The infection or bubble up model does not depend on top level commitment, but uses voluntary pilot programs to demonstrate success and then promotes the

CQI philosophy through the organization by reference to those programs. This approach encourages individual and group initiative; however, it lacks commitment and direction from senior officers that is so important to successful implementation.

The loose-tight model is an approach in which senior officers function as participants, facilitators, and leaders. The officers demonstrate commitment by engaging in detailed and comprehensive planning that involves employees. This model combines the strengths of the cascading and infection models.

No matter what model or approach is used, the transformative change that Deming advocated is difficult to achieve. One can only cite the facts that support the notion that involving workers in organizational decisions coupled with continuous quality improvement can provide better outcomes (Lawler et al., 1992). However, offering facts will not win converts, because people do not operate factually. People operate emotionally and emotions are controlled by belief. Furthermore, people generally resent being told that what they believe is wrong (Dobyns & Crawford-Mason, 1994). Our assumptions shape our view of reality. As you recall, Deming called these assumptions theories, and Senge calls them "mental models," and Morgan calls them "metaphors." The mechanistic view of people, organization, and management is so ingrained in the American collective conscious, that I am tempted to call this belief system a paradigm (Kuhn, 1970). Americans who write about the quality movement, such as Martin (1993), exemplify the ubiquitous nature of the mechanistic worldview. For example, in writing about the applicability of CQI in human services, he writes about empowerment

and teamwork, but he then emphasizes top-down management, statistical processes, the seven quality tools, and the external customer. There is an almost universal tendency wherein American managers narrowly understand CQI in terms of statistical processes, problem solving tools, and satisfying the external customer.

Generally, most CQI efforts give priority to teaching statistical process control and the quality tools. However, Senge (1991) estimates that the statistical process control and problem solving tools are only 2% of CQI, while the essence of CQI is “mobilizing the intellectual resources of everyone working for a company” (p. 2). Though American managers talk about the importance of empowerment and teamwork in CQI, they predictably behave in a mechanistic manner.

Argyris (1984) believes that the tendency to behave differently from one's espoused theory generally indicates a learning disability. Correcting the disability by bringing one's espoused theories in line with one's theories-in-practice, is difficult because of defensive assumptions. The ingrained view of organization-as-machine obscures the theory that there are two equally important customers in CQI—the internal customer and the external customer. This problem has resulted in the needs of employee-as-customer being relegated to a secondary or peripheral position in the CQI research literature (Hunt, 1992). Again, this is not to say that the need to focus on the worker is unrecognized. Glazer wrote the following:

While TQM leads to external goods, the true motivation, and stimulant of successful TQM programs has been what MacIntyre would label as goods inter-

nal to a practice or what others would call 'intrinsic benefits'. In the educational community, this might be the satisfaction a teacher receives when he or she receives positive feedback from students. (p. 16)

What is frustrating to managers is that they continue to have trouble even when they attempt to understand and address the needs of employees. Managers do not know whether to be dictators or liberators because the literature is ambiguous.

Job Satisfaction and CQI

For over fifty years, industrial psychologists have been trying to understand the reactions of people in organizations, including their conflicts, adjustments, motivations, satisfactions and dissatisfactions, and how these reactions affect the overall performance or effectiveness of the organization. Bywaters (1991) effectively argues the mechanistic view that tightening control from the top can increase productivity, and those high levels of productivity result in high levels of job satisfaction. However, "the research does not support the theory that rewards, intrinsic or extrinsic, which are based on performance lead to satisfaction and subsequent performance" (Dessler, 1986, p. 205). Tannenbaum (1992) appears to straddle the fence on this issue of whether tightening control from the top or liberation of the worker increases job satisfaction and productivity. He believes that there is a need to increase the influence of both the rank and file employees and management in the organization's decisions. According to Tannenbaum, the old view of increasing productivity and satisfaction by tightening control from the top is antiquated. He then waffles by citing a study that indicates

that job satisfaction and productivity could be increased by tightening control at the top or by placing greater control in the hands of workers. DeWitt (1980) has studied organizations controlled by a few at the top. She documents how hierarchical administration leads to low self-esteem, poor morale, and alienation among workers. In extreme cases, according to DeWitt, alienated workers deride and sabotage their own organization.

Autocratic behavior is incompatible with CQI. However, CQI is not just about job satisfaction as exemplified in the human resource literature. Boman and Deal (1990) describe the human resource approach as one essentially attempting to find a fit between the organizations goals and the worker's needs. Job satisfaction is a primary concern for the proponents of the human resource approach. Dessler (1986) defines job satisfaction "as the degree to which one's important needs for health, security, nourishment, affiliation, esteem, and so on are fulfilled on the job or as a result of the job" (p. 204). He wrote, "While the idea that happy employees perform better is intuitively appealing, the research findings generally fail to support it" (p. 205). There are many factors correlated with job satisfaction. Dessler (1986) has identified age, educational level, occupational level, central life interests, leader style, work group affiliation, organizational climate, pay, type of work, and nature of work as a few of many factors that influence job satisfaction.

For instance, older workers tend to be more satisfied than younger workers who might have unrealistic expectations. Job satisfaction also increases with the level of education. Executives tend to be more satisfied than managers, and

managers are generally more satisfied than subordinates. Employees for whom work is a "central life interest" also tend to have high levels of job satisfaction. Workers who have more considerate managers are generally more satisfied. Workers who are part of a cohesive work group are generally more satisfied. Even the perception the individual has of the organization for which he or she is working influence satisfaction. The way the worker feels about the organization in terms of autonomy, structure, rewards, consideration, warmth, and support, and openness will influence whether he or she is satisfied. Pay, not only in terms of adequacy of the pay, but in terms of whether or not it is equitable influences whether or not a worker is satisfied. Finally, the nature of a person's job influences job satisfaction, because in order to feel important, the worker needs to be challenged to achieve (Dessler, 1986).

The reason job satisfaction is so important is that we know intuitively it can improve the bottom line. In the book Why TQM fails and what to do about it, Brown et al. wrote: "Some forward-thinking companies like Marriott and Federal Express believe that employee satisfaction is the first step to customer satisfaction. Employees happy with their job, their compensation, and their organization do more to delight customers" (1994, p. 95). Although CQI may bring about job satisfaction, the focus is much broader in scope.

First, concerning CQI, there is a critical distinction between the terms "job satisfaction" and "morale." "Individual employees have attitudes and composite job satisfactions, but only groups of employees can reveal morale (Benge & Hickey, 1984, p. 11). While high morale does not always lead to increased pro-

ductivity, Benge and Hickey (1984) have clearly documented the "connections between high morale and increased productivity" (p. 7). The potential for CQI to improve morale is important, because today's organizations must compete on both a human as well as a financial basis to survive (Kanin-Lovers, 1990).

Second, CQI as espoused by Deming, is about allowing workers to become a part of a larger communal organizational vision and purpose. It is about training and empowering workers to make decisions about their job. Moreover, CQI is about treating workers like human beings. That is why Deming said that workers have the right to enjoy their work. Morale, concerning CQI, has to do with satisfying the workers' intrinsic needs in terms of being a member of a team committed to a purpose and continuous improvement. Empowerment is achieved through collective learning and action oriented toward transformative change for mutual personal and organizational purposes. Empowered workers' in CQI typically collaborate. Their activities revolve around competition with other organizations through the continuous improvement of their work environment, service to each other, and the external customer. The Japanese call this concept kaizen.

Comprehensive data about employee morale aids in the success of CQI. Brown et al. wrote: "Many large corporations limit the data they collect on employee satisfaction to an employee morale survey conducted every two years" (1994, p. 95). First quality organizations regularly collect data on morale. Management has come to realize that addressing the needs of the internal customer increases the likelihood of an organization's success. Such organizations re-

solve the crisis of productivity because workers empowered through CQI can delight customers (Bachrach & Botwinick, 1992).

Empowerment and CQI

High morale among workers is correlated to empowerment. While CQI requires empowerment of workers, it is not just about empowerment.

Empowerment without constancy of purpose or appropriate training can lead to chaos. On the other hand, empowering employees involved in CQI to experiment and take calculated risks is requisite to invention and innovation necessary for delighting the external customer. Navaran (1992) believes empowerment of employees should go beyond giving workers power to participate in work-related decisions. He advocates encouraging workers to accrue power to themselves and apply this power to their jobs. Block (1993) makes an issue of the fact that, "when we enter the factory door or the lobby of the business cathedrals in our major cities, we leave our belief in democratic principles in the car" (p. xii).

Pateman (1970), and Bachrach and Botwinick (1992) believe that ultimately, inclusive organizations develop responsible citizens, which increases the level of democracy in society. Pollitt and Buckaert (1995) characterize such views when applied to the purpose of CQI as "foolish" (p. 14). In the same vein, Rost (1993) wrote that management is inherently coercive; consequently, CQI is not about the creation of a democratic organization.

No one would argue against the creation of responsible citizens. In fact, the concept of kaizen incorporates improvement of the workers' social sphere. Furthermore, organizations have to be prepared for scrutiny of their behavior con-

cerning how they treat their workers. For example, a new area called “socially responsible investment” has developed in the marketplace. Today purchasers of goods and services frequently boycott businesses perceived as unfair to workers. In fact, the idea of social responsibility is very compatible with the goals of CQI, because quality-first organizations are concerned ultimately with the continuous improvement of its people and products. Following are models of empowerment compatible with CQI.

Brown et al. (1994) discusses several specific strategies that organizations have used to empower employees. Quality circles, borrowed from Japan, became popular in America as a way of empowering workers. Quality circle team members receive extensive training on group decision making, quality techniques, and group dynamics. Participation is usually limited to periodic voluntary meetings. Quality circles often involve cumbersome hierarchical committees operating outside the normal chain of command. A study of CQI efforts in 131 organizations over 30 years, showed that although many critical problem-solving and group process skills were learned, quality circles and similar team problem-solving structures can have a negative impact on financial performance. Cumbersome committee structures and processes apparently increased costs and bureaucracy overall (Brown et al., 1994).

Participative management, another popular worker empowerment strategy, became an accepted management practice following McGregor’s (1960) work published on “Theory Y” and “Theory X” management styles. It is defined as managers sharing their power and influence by regularly asking employees for

input while maintaining at a minimum a veto over their ideas. Participative management represents a significant departure from the mechanistic view, because employees participate in the decisions of the organization. However, in participative management, the power structure remains unaltered because managers are still firmly in control.

Deployment of self-directed teams, on the other hand, significantly alters the power relationship between the managers and the workers. When self-directed teams are developed, management gives up its veto around clearly defined areas of responsibility. The self-directed team assumes most, if not all, of the responsibility of a traditional supervisor. These teams plan, implement, and evaluate their work. For example, they may interview potential candidates for a vacancy, as well as train and appraise their members. They also may have direct contact with customers and suppliers. Often, team members are cross-trained, and job classifications are combined, leading to increased flexibility. Some self-directed teams hire, fire, and compensate their members.

When the power structure is significantly altered—as with self-directed teams—performance tends to improve dramatically. According to Lawler et al. (1992), significant improvements in performance generally do not occur until management relinquishes power to the self-directed team. Until that happens, true power has not shifted, and involvement is often interpreted as tokenism. However, once delegated official responsibilities, self-directed teams, and the performance of the organization takes off.

While the work may place limitations on the degree of empowerment that is practical, over 45 years of data support the conclusion that redesigning the workplace around high-performance, self-directed teams yields quantum leaps in performance. They yield significant improvements in quality, decision making, work methods, employee retention, and safety. Furthermore, they have worked successfully in a variety of settings, including manufacturing, schools, government, health care, and financial services (Brown et al., 1994; Lawler et al., 1992).

CQI in Health care

Case studies from the perspective of the worker are important because the concept of CQI must underlie the strategic decision to implement a managed health care system (Phoon, Corder, & Barter, 1996). Nevertheless, researchers in the health care field have only scratched the surface insofar as using CQI to address the needs of internal customers (Hunt, 1992). Therefore, clinicians remain unaware of how CQI can benefit specifically them as well as their patients.

Continuous quality improvement (CQI) as a method of improving quality has gained worldwide acceptance. We now know that CQI can increase the efficiency, effectiveness, and performance of organizations. In her book: Deming Management at Work, Mary Walton (1990) presents case studies of CQI efforts at the Florida Power and Light company, Tri-Cities, Tennessee, The United States Navy, Bridgestone (USA) Incorporated, Globe Metallurgical Incorporated, and the Hospital Corporation of America. These case studies demonstrate that CQI has successfully implemented in various industries. However, such case studies are broader in scope than those needed to help us understand the use of

CQI from the workers' perspective. In addition, CQI is relatively new in health care compared to other industries. However, the economic and political pressures make CQI irresistible to purchasers of health care.

Despite cost-reductions in health care, the pressure to improve the quality of patient care and other outcomes has increased (Kirk, 1992). CQI has had success in industry, and health care executives are interested in adapting this approach to the health care environment. Consequently, health care providers, purchasers, and insurers no longer consider CQI a fad. Most of the CQI efforts in hospitals and medical outpatient settings are under the rubric of a quality management program. The methods, settings, and specific purposes for which CQI is used vary widely. Each reported study of CQI seems to be unique in terms of methodology.

For example, Metcalf (1992) conducted a study of CQI at Alliant Health System, a health care provider in Louisville, Kentucky. Alliant implemented CQI in conjunction with critical path process as a managed care strategy to deliver cost-effective quality patient care. CQI studies related to cost-reduction and patient outcomes are typical in health care. The 1994 study reported by Anderson, for instance, demonstrated how CQI reduced monthly medication replacement cost in a Wisconsin hospital by half, within a four-month period.

Researchers studying CQI in mental health have also focused on cost reduction and patient outcomes. For example, Chowanec (1994), Vermillion and Pfeiffer (1993), and Rago and Reid (1991) show how CQI was used to enhance

and evaluate patient outcomes in psychiatric hospitals for the chronically mentally ill.

An example of less common, but important, uses of CQI is a study conducted by Kaluzny, McLaughlin, and Simpson (1992). Their study documented how CQI improved standards of an assessment protocol in a North Carolina public health center. Although the goals of cost reduction and improving patient outcomes remain the primary focus of CQI research in health care, there has been an effort in health care to use CQI to empower patients. Sukati (1995) conducted a study of CQI with an emphasis on patient participation.

Though rare, there are CQI studies in health care that focus on employee morale. Churchill (1992) conducted a three year study of the effects of CQI in a dialysis center beset by low morale and high turnover. The results were an increase in job satisfaction from 40% to 92%, a reduction in turnover from 70% to 5%, and a reduction in absenteeism from an average of 8 days per year, to 2.5 days per year. This same study showed productivity, as measured by Medicare program deficiencies, dropped by half.

In conclusion, our knowledge remains incomplete as to how to implement CQI to build learning organizations that improve morale and increase quality. Again, Brown et al. (1994) place the odds of an organization successfully implementing CQI at "two to one—against" (p. 24). Because morale is such a critical factor to quality, better understanding of how to effectively implement CQI should become the number-one priority for mental health service organizations. The literature suggests a need for studies of how specifically to implement CQI to assess, im-

prove, and maintain morale in community mental health settings. There is a special need for a study, from the perspective of community mental health workers, of the implementation of CQI to address morale.

The first step toward increasing our knowledge is learning more about the perceptions and needs of the internal customer, the worker. Though CQI has been shown to be a useful process to address morale (Churchill, 1992), there is a lack of knowledge about how to address morale through the implementation of CQI in a community mental health setting. The literature suggests the need for a qualitative case study, which can generate descriptive step-by-step, first-hand data, based on the perceptions of workers and others..

CHAPTER 3: RESEARCH METHODOLOGY

Qualitative Methodology

Qualitative methodology, a method embraced by postmodernists, is also referred to, with slight variation in meaning, as naturalistic, hermeneutic, interpretist, and constructivist methodology (Guba & Lincoln, 1989). "Qualitative research is a particular tradition in social science that fundamentally depends on watching people in their own territory and interacting with them in their own language, on their own terms" (Kirk & Miller, 1986, p. 9). "In general we have been conditioned to think of research as a process that uses an instrument, involves a large number of people, and is analyzed by reducing the data to numbers" (Glesne & Peshkin, 1992, p. 5). This "quantitative" view of inquiry is deeply ingrained in western culture and is based upon a mechanistic worldview. The quantitative view of inquiry made possible the modern western industrial revolution. Therefore, it is not surprising that society continues to embrace rationalism as the foundation for science (Walker, 1996). Today, science based on rationalism is often seen as the only valid way to conduct research. Consequently, "qualitative research [is not as familiar, and] does not have the general acceptance that quantitative [also referred to as scientism, conventional, and positivist] paradigms enjoy. Therefore, more attention must be devoted to a sound rationale for qualitative designs than with quantitative [research] proposals" (Marshall

& Rossman, 1989, p. 144). Qualitative methodology has been in existence for several hundred years, and today it is closely tied to the postmodern view. The postmodern “stresses that there is a multiplicity of meanings and interpretations of reality and that science is but one, rather privileged one” (Walker, 1996, p. 52). According to Walker (1996):

Postmodernism refers to a method of analysis first developed in literary theory of the 1960s as a reaction against modernism and structuralism. Sometimes called poststructuralism, this mode of analysis attempts to deconstruct conceptions of reality and as such challenges the very foundation of truth and knowledge. The world is not objectively real; the subject is no more than illusion. The world is to be taken as a text that has meaning only as it is read and interpreted by the reader. There is no absolute reality, reality is subjectively determined. (p. 56).

Because of the postmodern subjectivist worldview, the role of the qualitative researcher is vastly different than that of the researcher in quantitative inquiry. Here, Glesne and Peshkin (1992) compare the two:

In quantitative research, the researcher’s role is to observe and measure and care is taken to keep the researcher from “contaminating” the data through personal involvement with research subjects. Researcher “objectivity” is of utmost concern. . . . Qualitative researchers [in contrast] deal with multiple socially constructed realities or “qualities” that are complex and indivisible into discrete variables, they regard their research task as coming to understand and interpret how different participants in a social setting construct the world

around them. To make their interpretations, the researcher must gain access to the multiple perspectives of the participants. Their study designs, therefore, generally focus on in-depth, long-term interaction with relevant people in one or several sites. The researcher becomes the main research instrument as he or she observes, asks questions, and interacts with research participants. (p. 6)

Ultimately, "the research methods we choose say something about our views on what qualifies as valuable knowledge and our perspective on the nature of reality" (Glesne & Peshkin, 1992, p. 5). Modernists are associated with the quantitative view, and postmodernists are associated with the qualitative view. They are distinguished by their assumptions about the nature of knowledge and reality. Qualitative methodology is characterized by a unique set of assumptions about the nature of knowledge and reality. According to Guba and Lincoln (1989), the qualitative and quantitative belief systems are distinguished by the way they answer three questions that philosophers have asked themselves, since time immemorial, about the nature of knowing. They teach that quantitative and qualitative belief systems are distinguishable paradigms. A paradigm is the predominant way a scientific community perceives, thinks, values, and conducts research based upon a particular view of reality (Kuhn, 1970). Qualitative and quantitative paradigms can be distinguished by the way they answer these three questions: What is the nature of reality?; How do we know what we know?; and, How can we learn what we do not know?

The first question is ontological and asks: What is the nature of reality? The quantitative view of reality conceptualizes reality as a single concrete, discoverable structure. Reality according to the quantitative perspective is realist (Guba & Lincoln, 1989). Reality operates according to immutable laws, some of which take cause and effect form, and are independent of the observer's beliefs. The metaphor that best exemplifies this materialistic view of reality is organization-as-machine (Hunt, 1991).

The qualitative view reality is relativist (Guba & Lincoln, 1989). Reality is conceptualized as social construction. To constructivists, reality is the sum of group beliefs. Accordingly, these multiple constructed realities do not operate according to any natural laws. Metaphorically, organization as a socially-constructed-brain, best exemplifies this view. For example, people in an organization continually provide information to each other in order to mutually regulate reality, and to adapt, invent, and innovate within a specific context or environment. In this regard, reality is constructed, and many different language games are played in organizations to control meaning and value. This explains why several realities, on multiple levels exist in organizations (Hunt, 1991).

The second question is epistemological and asks: What is the origin, nature, and limits of human knowledge? How can we be sure that we know what we know? The quantitative view holds that we can know about the reality "out there." This positivist assumption also claims that the only conceivable way we can acquire knowledge is through our physical senses, and perhaps through some sort of information transmission through our genes (Harman, 1988). Ac-

cordingly, it is believed that we can only trust what we know, when we deduce what we know by rational, objective (value free), and scientific (statistical) behavior.

The qualitative paradigm, on the other hand, asserts that knowing is a process of accepting beliefs given birth by interaction between the researcher and the researched, in a particular relationship, and in a particular situation. The relationship between the researcher, the researched, and the context are inherently value-laden and inextricably interwoven. The findings of any research are thus creations of the inquiry (Guba & Lincoln, 1989).

The third question is: What are the ways of finding out knowledge? This is usually called the methodological question. Another way to phrase this question is: "How can we go about finding out things" (Guba and Lincoln, 1989, p. 83)? The quantitative camp believes that in order to study a phenomenon they must first reduce it to its basic interactive components called variables. Only then can they study the measurable world using their physical senses that are frequently augmented by instrumentation (Harman, 1988). Quantitative research is ultimately concerned with verification or explaining the reason or cause of a phenomenon so that it can be predicted and controlled.

Constructionists invariably believe that there is a difference between the study of nature and the study of human action. Human action is seen as influenced by an inappreciable number of the social structures in which we live. Consequently, qualitative methodology tends to be hermeneutic. Hermeneutics is a theory and method of interpreting human action within a given context. The "hermeneutic

circle” is a method whereby the inquirer submits his/her findings for the critique and analysis by participants and other stakeholders. According to constructivists, these iterations eventually lead to the emergence of valid constructions which are considered temporary and subject to further revision. Ultimately, qualitative methodology is concerned with obtaining successively better understandings of the whole of a social phenomenon, as well as its relationship to its parts.

Qualitative research “can cover a vast range of research styles . . . [and,] there is no standard approach among qualitative researchers” (Silverman, 1993, p. 23). According to Silverman, there are four principal methods that qualitative researchers use to conduct research in the social sciences. They are recording and transcribing, analyzing text and documents, the individual interview, and observation in groups. To a lesser degree, focus groups are used to collect data. Focus groups combine elements of both participant observation in groups and individual interviews (Morgan, 1988). Silverman has also found that though constructivists are primarily concerned with observation, discovery, and generating hypotheses, more of these researchers are incorporating hypothesis testing into their qualitative research designs. Hence, the use of qualitative methodology “does not imply a commitment to innumeracy . . . [or] things not quantitative” (Kirk and Miller, 1986, p. 10).

Here Denzin & Lincoln (1994) provide an excellent summary of the eclectic nature of qualitative methodology:

Qualitative research is multi-method in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative

researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meaning people bring to them. Qualitative research involves the studied use and collection of a variety of empirical materials . . . Accordingly, qualitative researchers deploy a wide range of interconnected methods, hoping always to get a better fix on the matter at hand. (Denzin & Lincoln, 1994, p. 1)

Bear in mind that many of the defining principles of quantitative methodology are inappropriate in qualitative research methodology. Silverman (1993) wrote:

The following assumptions are highly dubious in qualitative research.

1. All social science research can be only valid if based on experimental data, official statistics or random sampling of populations.
2. Quantified data are the only valid or generalisable [sic] social facts.
3. Having a cumulative view of data drawn from different contexts allows us, as in trigonometry, to triangulate the 'true' state of affairs by examining where the data intersect. (1993, p. 152)

This researcher's view is consistent with that of Silverman with regard to which methodology is best. He believes, like theories, methodologies can not be true or false, only more or less useful.

Qualitative Case Study

A qualitative case study is a specific method or technique within qualitative methodology. It is an empirical, inductive method in which the researcher is the primary instrument for "intensive, holistic description and analysis of a single instance, phenomenon, or social unit" (Merriam, 1988, p. 20). A qualitative case

study seeks to contribute to our knowledge and understanding of a contemporary phenomenon by providing reliable and valid insights about a particular social setting or event.

Toward that end, multiple methods are utilized (Kirk & Miller, 1986; Yin, 1989). The ultimate aim of qualitative case study method is to document the research from the perspective of informant (s) by providing “thick description” (Spradley, 1979). Denzin (1988) explains that “thick description goes beyond the mere reporting of an act (thin description), but describes and probes the intentions, motives, meanings, contexts, situations, and circumstances of actions” (p. 39). Qualitative case study method is indicated in this investigation, because it is uniquely suited for documenting the step-by-step implementation of CQI from the perspective of the worker and other study participants. The qualitative case study is also the most effective method to gather the perception data asked for in the research questions.

Objectivity: Reliability and Validity

“The first goal of scientific research is valid knowledge” (Silverman, 1993, p. 154). Contrary to what many researchers and others believe, the way valid knowledge is obtained in qualitative research is through objectivity (Kirk & Miller, 1986). Objectivity means, in this regard, that the knowledge generated from qualitative research must have merit other than what the researcher feels or thinks happened. As one might expect, the way in which objectivity in qualitative methodology is defined is different than how it is defined in quantitative research. Here, Kirk and Miller (1986) discuss objectivity from a qualitative perspective:

Objectivity, though the term has been taken by some to suggest a naive and inhumane version of vulgar positivism, is the essential basis of all good research. Without it, the only reason a reader of the research might have for accepting the conclusions of the investigator would be an authoritarian respect for the person of the author. Objectivity is the simultaneous realization of as much reliability and validity as possible. Reliability is the degree to which the finding is independent of accidental circumstances of the research, and validity is the degree to which the finding is interpreted in the correct way. (pp.19-20)

For qualitative researchers, the issues of reliability and validity are treated as issues of accuracy in observation. Therefore, reliability and validity are assured by different methods and strategies in qualitative methodology than those methods and strategies in quantitative methodology. Let us begin with the issue of validity. Silverman (1993) has argued that, "the issue of validity is appropriate whatever one's theoretical orientation or use of quantitative or qualitative data" (p. 156). Merriam (1988) has identified six basic strategies an investigator can use to insure internal validity in qualitative research:

1. Triangulation, i.e., confirmation of the accuracy of emerging findings through the use of multiple investigators, multiple sources, and multiple methods.
2. Member checks, i.e., confirmation of emerging findings by checking with informants and respondents to see if they are plausible.
3. Long-term observations, i.e., confirmation of emerging findings by gathering data repeatedly over time at the research site.

4. Peer examination, i.e., confirmation of emerging findings through colleagues critique and input.
5. Participatory modes of research, i.e., involving participants in every aspect of the research.
6. Researcher's bias, i.e., identifying, clarifying, and addressing researcher's biases throughout the study.

Generalizability

Another issue related to validity has to do with the generalizability of research. Generalization in qualitative research may be attempted in terms of making a generalization to a theoretical proposition, but never to a population (Silverman, 1993). With regard to generalizing a case study across settings, Marshall and Rossman (1989) wrote: "A qualitative study's transferability or generalizability to other settings may be problematic" (p. 146). Generalizing from a single case, selected in a purposeful rather than a random sampling is not appropriate. Qualitative case study research is conducted to understand a particular phenomenon in-depth, not to understand what is generally true, or cause-and effect relationships between variables (Merriam, 1988).

Site Selection

Neighborhood House Association was established as a settlement house in 1914 and incorporated in 1923. It has been under the direction of Dr. Howard Carey, President, and CEO since the early 1970s. One of the largest non-profit social and health services organizations in the nation, Neighborhood House Association has an annual budget of around \$30 Million, and provides services to

approximately 300,000 clients. As a Licensed Clinical Social Worker with San Diego County Mental Health Services, over a period of nine and one-half years, the researcher developed working relationship with a number of the programs within Neighborhood House Association including Project Enable.

Project Enable, the research site, is a division of Neighborhood House Association contracted by San Diego County to provide outpatient mental health services. Project Enable consists of three interrelated outpatient community mental health programs. These three programs constitute Project Enable's Continuing Community Treatment and Care system (Medication Management, Socialization, and Day Rehabilitation). Among other factors detailed below, Neighborhood House Association, Project Enable was selected as the study site because authorities decided to implement CQI and the literature suggested a need for a study. Literature suggested a need for a study, from the perspective of the workers, of how morale is addressed through the implementation of continuous quality improvement (CQI) in a private-sector community mental health organization.

Following is a description of the Project Enable Day Rehabilitation program selected as the site for the study. The Day Rehabilitation program has a staff of seven who serve an average of 40 persistently mentally ill patients. The Day Rehabilitation program is for patients hospitalized within the past six months before admission. It operates Monday through Friday, and treats patients with psychotropic medications and group therapy in a structured, partial-day therapeutic environment.

There were several other reasons for selecting the Day Rehabilitation program as a setting for this study in addition to the fact that CQI was being implemented. First, like Project Enable, the majority of mental health programs in the future will probably be located in private-sector community mental health centers. Second, Project Enable is located in Southeast San Diego, which is culturally and ethnically diverse. Third, Project Enable treats the persistently mentally ill adult population given top priority by San Diego County Mental Health Services. Fourth, before the study, staff turnover has been the lowest among the three programs (no turnovers in two years). Relatively small stable programs, like the Day Rehabilitation, are optimal for long-term, in-depth qualitative case studies. Fifth, Neighborhood House Association has a traditional administration, management, and decision-making process that is willing to change. The Neighborhood House Association, Project Enable administration, and management are accessible to the researcher, and committed to change through the implementation of CQI. Finally, authorities in Neighborhood House Association, Project Enable, and authorities in San Diego County Mental Health are interested in the study of morale and CQI from the perspective of the worker.

The Participants

The primary participants in this study are the staff of the Day Rehabilitation program. They were purposely selected for several pertinent reasons. First, the staff is a typical multidisciplinary community mental health treatment team. The treatment team consists of: One office manager who is an African-American female; two Marriage and Family Child Counselors who are both male (one is

European-American and the other is Hispanic); one male and one female mental health counselor (both of whom are African-American); one registered nurse who is an African-American female; and, one psychiatrist who is also an African-American female. Second, prior to the study, this team had no previous experience with CQI or any other formal worker inclusion processes. Third, morale had been affected by cutbacks and the perception that upper management was out of touch with staff. Other participants are the director, and the CQI trainer/advisor.

Ethical Considerations

The potential benefits appear to have outweighed the potential risks for the participants in this study. There was no known expense to participants associated with the research. All research was conducted during regular business hours. To compensate for the lunch hour meetings, staff were given one-hour off at the end of the day on Fridays. Initially, the study was perceived as a threat to some participants. They were concerned because they were already having difficulty with confidentiality among themselves, and anonymity in such a small program was difficult to protect. They also were apprehensive that things they said might be held against them in some way.

Both the director and the researcher assured all of the participants that their participation in the study was strictly voluntary, and that every precaution to protect them would be taken. In addition, before the study began, all of the staff were given the opportunity to ask questions and express concerns, issues, and fears.

All participants signed informed consent forms that made it clear that anyone could withdraw from all or part of the study without jeopardy. The researcher presented only group and anonymous statements in this dissertation. Pseudonyms were used to protect the identity of the participants. Finally, participants were given an opportunity to identify statements in the dissertation that they perceived as inaccurate or threatening for revision.

Instruments and Data Gathering

Informed consent was obtained from all participants on the approved Informed Consent Form (Appendix B) before any data were collected. The researcher, with the aid of audio and video recording, was the primary instrument for data gathering. The researcher's primary role in this investigation was that of observer. Structured formal interviews occurred after the researcher obtained permission from the University of San Diego, Committee on the Protection of Human Subjects and notified the San Diego County Mental Health Services Clinical Staff Association, Research Standards and Oversight Committee.

Questionnaires and other sources of data collection.

There were five primary sources of data used in this study: The first was the "Motivation to Participate" (MTP) questionnaire (Appendix C). The investigator administered the unsigned MTP questionnaire to the workers at the beginning of the study. The literature strongly suggested the development and use of the MTP questionnaire. Brown et al. (1994) stress the importance of the use of "soft" data to get at workers opinions of how they would like to be treated. Soft data,

such as that obtained with the MTP questionnaire, can yield valuable information about workers' motivation to participate in the study of implementation of CQI.

The second source of data was Benge and Hickey's (1984) 32 item "Employee Morale Assessment" (EMA, Appendix D), which was reprinted with the permission of Grolier Publishing Company (Appendix E). The investigator administered the unsigned EMA questionnaire at the beginning and at the end of the study.

The third source of data was the San Diego County Mental Health Services, Training Evaluation (Appendix F). The staff process action team and the director completed the training evaluation form after the CQI training.

The fourth source of data was the description of the implementation in chapter four, including the researcher's observations of the implementation of CQI. This rich, systematic description of what transpired in the study was used to address all of the research questions.

The fifth source of data was the Individual Interviews (Appendix G). The researcher administered the Individual Interview questionnaire to participants near the end of the study. This questionnaire was developed specifically to answer the research questions, as well as other pertinent questions that emerged during the study. Using the Individual Interview questionnaire in structured individual interviews, the researcher asked the staff process action team about their perceptions of the CQI implementation.

The MTP Questionnaire.

Neighborhood House Association, Project Enable management determined that CQI would be implemented in the Day Rehabilitation program. The investigator was compelled by the research questions and literature to develop a MTP questionnaire. The literature was compelling about the necessity to explore employees' motivation to participate in CQI. Payne (1992) advised that when a proposed CQI program is contemplated, one should ask what is the payoff for the workers to implement the program. In the same vein, Milite (1992) asserted that in order for CQI efforts to be effective, workers need to be consulted both individually and also as a group, to determine their willingness to participate. Moreover, research question number two (b) asks: "What motivated workers to follow through or not follow through with specific processes? The MTP questionnaire addressed the issue of motivation.

Kirk and Miller (1986) wrote that asking the wrong questions is the source of most validity errors. In this case, asking the participants how they felt about implementing CQI might have elicited the "party line." Employees frequently tell management what they think management might want to hear. To avoid this type of error common to all research, the questions in the MTP questionnaire focused on the participants' motivation to participate in the "study." The questions on the MTP questionnaire were open-ended and were constructed to elicit the workers' feelings about participating in the study of the implementation of CQI, as opposed to the implementation of CQI initiated by management.

Although it was explained that the questionnaire would be unsigned and that the answers on the questionnaires would be aggregated to protect the participants' identity, asking questions about participant's motivation to participate in the study of CQI was considered necessary by the researcher to make the MTP less threatening to respondents. The study was considered less threatening because it was voluntary. The employees had the power to decide whether to participate in the study. Consequently, the researcher believed that the participants were more likely to give honest answers to questions about their motivation to participate in the study of the implementation of CQI.

Questions one and two on the MTP questionnaire get directly to Payne's (1992) issue of the worker's motivation by asking: First, "What motivates your participation in this study?" Second, "What are your expectations?" Question number three elicited, in addition to what the workers expected, the worker's feelings in terms of issues, concerns, and apprehensions about the study of the implementation of CQI by asking: "What problems do you anticipate?" Asking this open-ended question allowed the workers to share their feelings. This information allowed the researcher to later address issues in a non-threatening and reassuring manner. Question four asked: "What concerns or questions do you have about the study?" This question elicited apprehensions, concerns, or questions from the worker that would also later be addressed in a non-threatening and reassuring manner. Question five asked: "What kind of training do you think you will need beyond that which was discussed?" This question allowed the workers to identify training needs that were not anticipated.

The Employee Morale Assessment Questionnaire.

The EMA questionnaire is held out by its authors to be one of the most efficient methods available to assess employee morale. According to Benge and Hickey (1984), at least three methods have been devised to study employee morale: The first method is analyzing company records for changes in productivity, attendance, and complaints. This is considered to be an inefficient method because it measures effects not causes. Interviewing employees is a second method. However, this method is usually costly and time consuming. The third, and preferred method, is administering anonymous questionnaires to groups of employees. The EMA was designed to be administered unsigned to protect the anonymity of the informants.

The Employee Morale Assessment (EMA) questionnaire developed by Benge and Hickey, and published in their book Morale and Motivation (1984) was selected to assess employee morale at Project Enable. The purpose for which the questionnaire was used in this study was two fold: First, to provide a descriptive, numerical baseline index of morale for the researcher and the participants to consider in the improvement effort. Second, as a way to compare and evaluate the scores and responses given by the participants at the beginning of the study, with the scores and the responses given at the end of the study. Although the authors did not specifically address the issues of validity and reliability in their book, they did reference selected findings from 144 studies in which the EMA questionnaire was used prior to the publication of their book.

Nevertheless, Kirk and Miller (1986, p. 32) point out that the field worker involved in long-term personal interactions, armed with a good theoretical orientation and good rapport is the best validity check in applied field research. In addition to the practical application of and usefulness of the EMA questionnaire, the researcher believed the EMA to be highly suited for this study because it is user friendly and standardized for tabulating scores and creating morale indices. In addition, the composite scores can be used to assess the morale of a program from one period to the next. The EMA questionnaire measures morale in a specific time frame which allows the scores to be compared over time to reveal trends.

The EMA questionnaire is divided into four parts. The introductory section of the questionnaire, explains the purpose of the questionnaire to the informant. It also reassures the employee of the anonymity of their responses. Part I elicits employees' age, earnings, tenure, and department. In the case of Project Enable, Part I data was not collected since the Day Rehabilitation program is such a small group.

The questions in Part II of the questionnaire elicit the worker's specific opinions on important issues related to morale. The questions in Part II are weighted so that numerical values were assigned. This allowed aggregate individual index scores to be converted into group morale indices. The calculation of the morale indices for Part II required the use of a tally sheet with space allocated for each question (Appendix H). The morale index is a weighted composite of five percentages. The "Extension" column in Appendix H shows the arithmetic score.

(Appendix H also provides the formula used to calculate the arithmetic score in the extension column.)

The value of morale indices becomes clear when the results are interpreted. For example, by itself, a morale index score of 67 for job satisfaction in the Day Rehabilitation program means little. However, by adding the scores for each index then dividing sum by the total number of questions, a composite score produces a profile of employee morale in the areas of workers' job, their boss, the company, and the environment. Standardized scores in Appendix I provide a benchmark to compare the results of the nineteen questions in Part II of the EMA questionnaire.

The authors suggest that morale surveys be conducted at specific intervals to see whether improvement efforts have worked, where morale is slipping or improving, and where to focus future efforts. Finally, survey results are compared to the standard scores provided by the authors to assure accuracy of interpretation. Service organizations tend to score higher, and small variations in scores are less meaningful in organizations of twelve or less.

This is an overview of how the EMA questionnaire was developed and how it was used as an instrument to measure morale. For the purposes of this study, it was intended to be a support to the assessment and the development of action plans to increase morale and productivity. More will follow on the analysis and treatment of the data generated by the questionnaire later when I discuss "Data Analysis."

To get respondents to give honest responses on the EMA questionnaire, Benge and Hickey (1984) wrote that an impartial person is less threatening to employees, and therefore, should administer the EMA questionnaire. They believed that employees were more likely to provide honest answers if a person from outside the organization administered the survey. They also stressed that the questionnaires must be administered simultaneously to a unit of employees. This reduced the possibility of employees collaborating on their responses. Furthermore, supervisors were not to be given the survey along with subordinates. This is like mixing apples with oranges. Supervisors must be surveyed as a separate group. To assure the validity of the responses, the researcher administered the questionnaires to the Day Rehabilitation employees.

The Training Evaluation.

A standard San Diego County Mental Health Services Training Evaluation form was used to assess the training participants' opinion of how valuable the training was. An average of the individual scores produced the group score.

The Description of the CQI Implementation.

The description of the implementation of CQI documented in chapter four is thick, step-by-step, chronological data about what transpired in the study. This data was a primary source used to answer the research questions.

The Individual Interview Questionnaire.

The following eight questions were asked of each of the staff process action team members near the end of the study.

1. What was your motivation to participate in the study in the beginning?

2. Why have you continued to participate in the in the CQI process?

Questions number one and two related to a key concept in the literature pertaining to what the perceived pay off was for employees to implement CQI (Milite, 1992). These two questions, also related to research questions number one and three: How is continuous quality improvement (CQI) implemented in a private-sector community mental health center? And, how is morale affected by the implementation of continuous quality improvement (CQI), as perceived by employees?

3. The process appears to have stalled temporarily at one point, why do you think that happened, and, did you take any personal initiative to move the process along; to keep it on track? Question number three related to the issues raised in research question number two: (b) what motivated workers to follow through or not follow through with specific processes, and (c) what were the problems associated with the study?

4. What did you like or did not like about the CQI training?

5. How compatible were the CQI tools to your needs?

Questions number four and five relate to research question number two: (a) what resources and training were needed.

6. Why did you not pursue the issues raised by the Employee Morale Assessment?

7. What were the problems associated with implementing CQI?

Questions number six and seven related to research question number two: (b) what motivated workers to follow through or not follow through with specific processes, and (c) what were the problems associated with the study?

8. How much time have you spent doing CQI above and beyond the meetings? Question number eight related to research question number five: How much staff and director time does the implementation of continuous quality improvement (CQI) involve?

Data Analysis

The natural inclination is to discount qualitative data analysis because qualitative data are not statistical and therefore not generalizable. Concerning the validity of data analysis, the reader is urged to bear in mind the thoughts expressed by Fielding and Fielding (as cited in Silverman, 1993): "Ultimately all methods of data collection are analyzed 'qualitatively', insofar as the act of analysis is an interpretation, and therefore of necessity a selective rendering" (p. 152). Moreover, qualitative data are not interpreted the same way in qualitative research as they are in quantitative research. Qualitative data are interpreted as representing the momentary constructions of people involved, as contrasted with the positivist interpretation of data as facts (Guba & Lincoln, 1989).

Correspondingly, data analysis is ongoing in virtually all qualitative research (Merriam, 1988, p. 119). For example, the "Motivation to Participate" (MTP) statements were compiled exactly as written and then submitted to the participants for discussion. Their responses to the data influenced the researcher's analysis. Specific details of how the MTP document was analyzed follow. The

point here, is that the investigator attempted to allow the participant's perspective to drive the analysis. This principle is critical to the process of qualitative case study data analysis.

The researcher attempted to incorporate the perspective of the participants in the data analysis report. Toward that end, the data analysis contains "thick description" (Spradley, 1979). Again, Denzin (1988) teaches that thick description goes beyond thin description (the mere reporting of an act). Thick description "probes the intentions, motives, meanings, contexts, situations, and circumstances of [participants'] actions" (p. 39).

One of the most important challenges for the researcher was to determine the most efficacious method to analyze the qualitative data generated in this case study. Pertaining to the question of what is the most effective, efficient, and productive way to analyze qualitative case study data, Yin (1989) wrote:

The first and preferred strategy is to follow the theoretical propositions that lead to the case study. The original objectives and design of the case study presumably were based on such propositions, which in turn reflect a set of research questions, reviews of literature, and new insights. (p. 106)

The purpose of this study was to provide, from the workers' perspective, data that is lacking about how continuous quality improvement is implemented to increase morale in a private sector community mental health center. This study focused on answering five research questions:

1. How is continuous quality improvement (CQI) implemented in a private-sector community mental health center?

2. How do employees and the director perceive the specific experience of implementing continuous quality improvement (CQI)? The study explored with workers and the director (a) what resources and training were needed, (b) what motivated workers to follow through or not follow through with specific processes, and (c) what were the problems associated with the study?

3. How is morale affected by the implementation of continuous quality improvement (CQI), as perceived by employees and the director?

4. How is quality of care, as perceived by employees and the director, affected by the implementation of continuous quality improvement (CQI)?

5. How much staff and director time does the implementation of continuous quality improvement (CQI) involve?

The data analysis attempted to answer the research questions above using the data from the principal sources described below.

In chapter five, *Findings and Analysis of the Study*, data from the Motivation to Participate survey, the Employee Morale Assessment survey, the training evaluations, the description of the implementation in chapter four, including the researchers observations, and the Individual Interviews were used to address the research questions.

Data Analysis Procedure

The data generated from the Motivation to Participate questionnaire was compiled (Appendix C&D) and submitted to the employees for analysis and discussion. The researcher's analysis of the data was guided by the responses given by the participants. The researcher analyzed the MTP data first from the

perspective of research question number 2 (b). In this regard, the researcher focused on what motivated the workers to participate in the study of the implementation of CQI. Second, the MTP data was analyzed from the perspective of the literature that corresponded to the research question. Specifically, the researcher attempted to determine from the answers given, what employees expected to benefit from the study of the implementation of CQI (Milite, 1992), as well as how workers responded to being consulted about their willingness to participate in the study of the implementation of CQI (Payne, 1992). This data is fundamental to the question of how CQI is implemented, because it probes the motivations and intentions of the participants for doing so.

The Employee Morale Assessment (EMA) questionnaire was administered at the beginning and at the end of the study. Ultimately, the EMA was used to address research question number three (How is morale affected by the implementation of continuous quality improvement, as perceived by employees?) by comparing the scores and the issues in the first and the second morale assessments. The results of the first survey were treated in the following manner. As specified by Benge and Hickey (1984), each section of the EMA questionnaire (Part II and III) were analyzed accordingly. First, the results of the EMA questionnaire were compiled (Appendix C&D). Part I of the assessment generates basic demographic data about the staff process action team participants. Part I data (the first four questions) were not collected.

Part II of the EMA was first compared to the standardized index in Appendix I. Then, the results were analyzed in terms of being above, below, or average in

comparison to the standard scores provided by the index. Part III asks for employees' written comments. The comments were typed exactly as written and compiled (Appendix C&D). The comments were then presented to the participants. This aspect of the analysis focused specifically on the discussion about the data by the group members. Moreover, the researcher felt it important whether or not the group subsequently addressed any of the issues identified in the survey during the CQI implementation.

The item scores and issues raised in the EMA survey at the end of the study (Appendix C&D, scores in bold print) were compared to the results of first survey and analyzed. The analysis focuses particularly on changes between the first and second survey. Again, the EMA was ultimately used along with other data to provide an answer to research question number three.

The training evaluation data was used to augment other data to address question number two: How do employees and the director perceive the specific experience of implementing continuous quality improvement (CQI)? This specific aspect of the data analysis explored (a) what resources and training were needed, and (c), what were the problems associated with the study related to training?

The data from chapter four, The Description of the Implementation was used to address all of the research questions. The question that animates observational data is, "what is going on here?" (Silverman, 1993). The chronological description of the CQI implementation in chapter four contains a selective rendering of what transpired and researcher observations. The researcher's observations

are, in effect, the researcher's interpretations of what was going at a specific point in the study. In order to accurately reflect what happened in this study from both the participants and the researcher's perspective, researcher observations and specific excerpts from chapter four were used in the analysis. The researcher analyzed this data in terms of both themes and unique perspectives throughout the study.

The Individual Interview questionnaire was constructed to specifically address the research questions, as well as other pertinent questions that emerged during the study. The informants' answers to the Individual Interview questionnaire were typed exactly as recorded, compiled, and analyzed in reference to the research questions. Concerning the analysis, the researcher asked himself: How do the informant's responses inform me with regard to the question?; And, what are the relevant themes or unique perspectives that apply?

The Case Study Report

This dissertation has six chapters. The first three chapters are The Introduction, Review of the Literature, and Research Methodology. The last three chapters are the Description of the implementation, Findings and Analysis of the Study, and Conclusions and Recommendations. The Description of the Implementation, chapter four, is a step-by-step, chronological account of what transpired during the study. The Findings and Analysis of the Study, chapter five, contains findings based upon the research questions and the literature, and analysis of the study. The last chapter, Conclusions and Recommendations contains the summary and the implications of the study.

CHAPTER 4: DESCRIPTION OF THE IMPLEMENTATION

Introduction

This chapter is a thick chronological description of the implementation of the continuous quality improvement process at the Project Enable Day Rehabilitation program. Pseudonyms are used to protect the names of the participants. The workers' activities are the primary focus of this description. This description is intended to provide the reader specific detailed information about how CQI was implemented from the workers' perspective. A detailed description allows the reader to determine the relevance and applicability of this case study. This chapter is divided into the thematic stages of the CQI implementation process at Project Enable. The stages are: How The Study Originated; The implementation of Continuous Quality Improvement, The Continuous Quality Improvement Training, The Initiation of the Continuous Quality Improvement Process, Identifying a Process to Improve, Developing the Proposal, and Presentation of the CQI Proposal.

How the Study Originated

The discussion about the pilot study of the implementation of CQI at Neighborhood House Association, Project Enable began with informal meetings between Fay, the director of Project Enable, and the researcher who was the Past President of the San Diego County Mental Health Services, Clinical Staff Association

(CSA) and a Doctoral student at the University of San Diego. Initial discussions centered around the director's concern about staff morale at Project Enable. The apparent problem was that a significant number of staff in Project Enable programs appeared to be apathetic toward their work; so much so that a consultant had been hired to work with the staff of one program. We explored some ideas about how to improve morale, and at the same time, improve the quality of care. As the Past President of the Clinical Staff Association, I had grappled with the problem of how to increase the morale of county employees and the quality of care. I shared with her my unique perspective based on my experiences with the Clinical Staff Association. The story that follows of how the Clinical Staff Association originated was relevant in this case because it is a story about an hierarchical organization attempting to improve morale and increase the quality of care through worker inclusion.

In 1987, after acknowledging that San Diego County Mental Health Services' (SDCMHS) had a morale problem, the director conducted an anonymous telephone survey. Upon completion, he concluded that both morale and the quality of care in mental health services suffered because clinicians lacked input into policies and practices. "Management alone can't do the job," he said. Later that year, he established the Clinical Staff Association. Its mission was to improve morale and the quality of care. Clinicians were given the responsibility to implement and maintain the CSA. The purpose of this voluntary organization was to provide a mechanism for clinicians to directly advise management regarding policies and practices that affect quality of care. Eventually, the Clinical Staff Asso-

ciation was opened to all county and contract staff directly involved in the provision of patient care. County staff constitute the majority of the clinicians in the Clinical Staff Association. Historically, only a few mental health contract staff participate in the Clinical Staff Association. Nevertheless, creation of the CSA formalized the employees' role in San Diego County Mental Health Services' (SDCMHS) quality assurance process.

The Clinical Staff Association's quality assurance role is broadly defined as a continuous quality improvement process consisting of problem assessment activities combined with solution oriented feedback to management. The CSA's specific quality assurance duties entail providing clinical standards and oversight, peer review, problem identification, analyses, proposing solutions, and providing feedback to management on pending decisions and policy issues that relate to quality of care.

Although the director gave the CSA credit for increasing morale and improving the quality of care in SDCMHS, there are no studies of the CSA's impact on morale or the quality of care. Beside the lack of impact studies, the CSA is widely perceived as a overly bureaucratic organization which, at one point, included over twenty-one committees.

The director of Project Enable wanted to avoid bureaucratic and expensive committees that characterized the Clinical Staff Association. She was interested in exploring particular concepts related to CQI such as morale and learning organizations. From the outset, we shared an interest in the view that promoting employee participation in the decision-making and the policy-making process in

service organizations could improve morale and improve quality of care. The literature supporting this view clearly suggested that the institutionalization of the role of the worker in certain decision and policy-making processes could increase morale and improve quality (DeWitt, 1980; Harris, 1989; Senge, 1990; Vroom & Jago, 1988).

Based on our experience and our knowledge of the literature, we agreed that the following concepts were the most important factors to understand about CQI: First, the internal customer, the worker, is equally important as the external customer. Especially in service organizations, CQI does not work unless the internal customer's needs are addressed. When approached from the perspective of the worker, CQI could increase morale and the quality of care. Second, little is known about how to improve the morale of workers by implementing CQI. Therefore, studies of CQI from the perspective of the workers are needed. Third, CQI processes vary widely; therefore, CQI efforts need to be customized to suit an organization's specific needs. Fourth, typical CQI efforts do not get the workers to buy-in because they are top-down and bureaucratic. Finally, clinicians in San Diego County Mental Health Services had resisted CQI efforts in the past, because they felt CQI was only appropriate for the manufacturing sector. Clinicians' resistance would be an important obstacle to overcome.

Once the director and the researcher arrived at the consensus above, we reviewed and discussed the different models of implementing CQI. We immediately ruled out most of the models that were suggested in the CQI literature because they were too top-down and bureaucratic. Typically, these models con-

sisted of a combination of the following kinds of committees. An Executive Steering Committee or a committee composed of top management; a Quality Management Board or a committee of middle managers; a Process Action Team or a committee of employees who implement the CQI plan and participate in problem identification and proposes solutions; and, a Quality advisor who acts as the CQI expert.

Aside from being top-down and bureaucratic, we knew that the executives in Neighborhood House Association and San Diego County Mental Health Services were not likely to approve any plan that contained a number of standing committees. Also, we knew that a proposal for a pilot study of CQI was more likely to get approval than a proposal for an organization-wide implementation of CQI. In light of the above, a proposal for a pilot with a minimum of standing committees appeared feasible. Although we did not agree with Crosby's advocacy of top-down CQI, we did believe what he wrote about that potential for CQI changing an organization. He wrote: "It only takes one person, one division, one group to change an entire organization" (1989, p. 112).

After two meetings, we decided that we would collaborate on a pilot study that focused specifically on the impact of the implementation of CQI to address morale and quality of care from the workers' perspective. We were both principally interested in implementing CQI without the bureaucracy. The goal was to structure a CQI process to improve morale and to increase the quality of mental health care by giving the staff a lead role in solving problems in their work area. The plan was to propose a pilot study in which one of Project Enable's three pro-

grams would be selected to implement CQI. Because the worker's perspective as well as knowledge of how to implement CQI to improve morale was lacking, I saw potential for a qualitative case study.

Implementing CQI is an expensive proposition even if limited to a pilot. A chief concern was how to obtain quality, cost-effective, CQI training and a CQI advisor with existing resources. We decided to propose that the San Diego County Mental Health Services, Resource Development Coordinator provide the training and be the quality advisor. He was a logical candidate because he was an experienced CQI trainer and advisor for San Diego County Mental Health.

I was excited that the director was attempting not only to implement CQI in an innovative way, but to bring about real change in her organization by changing the relationship between management and employees. It was at this point that I felt this was the perfect topic for my doctoral dissertation in leadership, because leadership is about transformative change (Burns, 1978; Rost, 1993).

The next step entailed discussing the proposal with the appropriate authorities. The director of Project Enable discussed the plan with the President and CEO of Neighborhood House Association, Dr. Carey; and I discussed our ideas with the San Diego County Local Mental Health Director, Stephen Harmon. I also discussed the plan with Dr. Zgliczynski, the chair of my dissertation committee at the University of San Diego. The outcome of these meetings was very positive.

Dr. Carey asked the director of Project Enable to set up a meeting between the three of us. Steve Harmon gave me tentative approval with his final approval

contingent upon my obtaining consent from the Southeast Mental Health Services Regional Manager, the Chief of Program Review and Development, the Clinical Staff Association, the University of San Diego Dissertation committee, and the University of San Diego, Committee on the Protection of Human Subjects. Dr. Zgliczynski liked my proposal to conduct a qualitative case study of how, from the workers' perspective, the implementation of CQI affects morale. However, she was concerned about my role as county employee conflicting with my role as researcher. She explained that in the past, a few doctoral students had experienced difficulty in attempting to fulfill the role of both researcher and employee. Among other things, she asked me to clearly delineate my role as county employee from that of researcher. Also, Dr. Zgliczynski understood why I had to get approval from the University of San Diego, Dissertation Committee and the Committee on the protection of Human Subjects, but she wanted to know more about how the Clinical Staff Association, the Southeast Mental Health Services Regional Manager; and the Chief of Program Review and Development fit into the approval process.

I explained: The Clinical Staff Association has a Research Standards and Oversight Committee that reviews all research proposals involving San Diego County Mental Health Clinical Services. Because my proposed study did not directly involve patients, only notification and annual progress reports were required of the researcher. As a county contractor, Project Enable is under the jurisdiction of the San Diego County, Southeast Regional Manager whose approval of the study is required. The Resource Development Coordinator is under the

jurisdiction of the Chief of Program Review and Development. Permission from the Chief was required for the Resource Development Coordinator to serve as a CQI trainer and advisor for the CQI pilot.

Next, the director and I met with Dr. Carey, the President, and CEO of Neighborhood House Association at the Neighborhood House Association corporate headquarters. He appeared enthusiastic and delighted about the proposal. Quickly, he pointed out that Neighborhood House Association had no interest in spending large sums of money and time on CQI committees. He inveighed against creating a bureaucratic CQI organization within Neighborhood House Association. We reassured him that the idea was to avoid unnecessary standing committees by using task force committees on an as needed basis. This idea is related, we explained, to the CQI concept of "just-in-time." Just-in-time is a continuous quality improvement philosophy of "making the right thing happen at the right time to satisfy the customer" (Adair-Heely, 1991, p. 11). We agreed that a pilot study of the implementation of CQI that focused on employee morale and quality improvement within one of Project Enable's programs was appropriate.

We further discussed the merits of the implementation of CQI and the study. Since there was not adequate experience or resources to support an organization-wide implementation, a pilot, we reasoned, would best allow Neighborhood House Association to start small and build on its successes. A pilot would allow management and the employees to experience the benefits and learn from pitfalls of CQI without great risk. Moreover, a pilot approach would allow the or-

ganization to acquire the experience and knowledge necessary to develop a CQI process that would work for Neighborhood House Association.

Later in the discussion we, agreed that my primary role was going to be that of researcher. As a county employee, I would be able to administer and report back the findings of the Motivation to Participate survey and the Employee Morale Assessment survey, as well as observe and support the implementation.

The outcome of this discussion was that the implementation of CQI would not be contingent on my research, since I had to go through an extensive approval process outside of Neighborhood House Association.

The consensus was that the focus of the CQI pilot would be to learn staff's perceptions of how the implementation of CQI affects morale and the quality of care. In deference to the literature, every effort was made to structure the process to avoid the actuality or the perception of a top-down approach. We agreed with the literature that in mechanistic organizations, the manager has to know it all and command and control the employees. Dobyns and Crawford-Mason (1994) wrote: "Quality methods need just the opposite—fewer supervisors and the complete involvement of the worker" (p. 23). We believed that one of the greatest challenges for organizations such as Neighborhood House Association which were attempting to implement CQI, is to get managers to accept that success of the organization rests on the capabilities of the workers (Dobyns & Crawford-Mason, 1994). Thus, it was mutually decided that the CQI staff would be given the sole responsibility for selecting their team facilitator, choosing which

process to improve, consulting with the CQI advisor or management, and obtaining training.

We realized that this bottom-up approach is contrary to the practiced CQI tradition of focusing on management and the external customer. Traditionally, management selects the facilitator and the processes to be improved. Besides, self-directed teams were based upon a bottom-up philosophy. However, the decision for a bottom-up approach in the pilot was based on more than philosophy. The bottom-up approach was desirable partly because we wanted to empower the workers, and partly because, historically, county clinicians had resisted top-down CQI efforts. Additionally, with the exception of the bureaucracy, the bottom-up approach had worked reasonably well in the case of the Clinical Staff Association. Moreover, we were impressed by the tradition of quality circles, a legacy of the bottom-up approach in Japan, institutionalized by Kaoru Ishikawa in the early 1960s (Dobyns & Crawford-Mason, 1994). Finally, my dissertation thesis concerned whether morale is increased and value is added when workers are given control over decisions that affect their jobs through the implementation of CQI.

According to Dobyns and Crawford-Mason (1991), the principal reason why bottom-up CQI efforts such as quality circles have failed in America, is that American managers did not really empower or listen to their workers. Giving the workers the responsibility for selecting their facilitator, selecting the process to improve, and obtaining consultation was an important first step toward empowerment. In view of the fact that it takes at least five years to implement

CQI, we decided to evaluate the progress of the CQI implementation after the completion of one or two processes, or one year. We left the meeting with Dr. Carey's input and approval to move ahead with the implementation of CQI in one of Project Enable's programs.

After extensive thought and deliberation, the Day Rehabilitation program was selected for the pilot implementation of CQI and the study. The plan was for the Day Rehabilitation staff to become the "staff process action team" who would select their facilitator and the processes to be improved. Because of patient scheduling, the Day Rehabilitation staff psychiatrist would not attend the CQI meetings. This did not appear to have a significant impact on the CQI implementation or the study. The plan was for the program coordinator to keep the psychiatrist informed. If needed, the CQI meetings could be rescheduled to include the psychiatrist. This was not intended to be routine however, because rescheduling the psychiatrist often meant rescheduling patients.

That aside, the staff process action team which consisted of the Day Rehabilitation staff, would be responsible for identifying a process to improve and making a formal proposal to the director. The director would then, if necessary, select and convene a guidance team comprised of individuals who would be involved in approving, directing, and supporting the process improvement effort. Particular members of the organization would be selected by the director to be a member of the guidance team, but only after the staff process action team selected a CQI process and presented a formal proposal to the director. This was

intended to eliminate the top-down and top-heavy bureaucracy usually associated with CQI efforts. This was our model of "just-in-time committees."

The guidance team was to consist of the director, as chair, and if necessary, other staff, managers, and support staff. The purpose of the guidance team was to (a) approve the staff process action team's proposal, (b) provide support, direction, and secure the resources necessary for the staff process action team to successfully complete a project, and (c) directly involve others who could help or would be affected by the project. There was some difficulty defining exactly what would take place after the proposal was submitted, because of the requirement to keep the process simple and just-in-time. We decided that the director would select a guidance team, but only if needed to carry forward the proposal and process.

Before my next meeting with the Project Enable director, I obtained approval from the Mental Health Service Regional Manager to conduct the study. I also obtained permission from the Chief of San Diego County Mental Health Services, Program Review and Development, for the Resource Development Coordinator to provide the CQI training and to act as a CQI consultant to Project Enable Day Rehabilitation staff.

The general plan was for the implementation to occur in late May or early June 1995. Initially, only the staff process action team and the director would be trained in continuous quality improvement. Others would be provided training as needed and just-in-time. As an employee, I would administer and report the findings of the Motivation to Participate and the Employee Morale Assessment

surveys. As an employee, I would observe the implementation. As a researcher, pending the approval of the University of San Diego Committee on the Protection of Human Subjects, I would interview the participants in the CQI implementation. The primary purpose of the interviews was to address the research questions. In anticipation of the study, I asked the participants to keep notes of their activities and impressions their about the implementation. The participants were promised an opportunity to review relevant chapters of the dissertation for revision and comments.

The Implementation of Continuous Quality Improvement

The first meeting with the Project Enable Day Rehabilitation staff took place in their basement office on the afternoon of June 29, 1995. In attendance was Diane, a counselor; Jane, a Registered Nurse; Ernie, a counselor; Ben, a psychotherapist and program coordinator; Cherry, the office manager; and, Loren, a psychotherapist with an engaging manner. We all settled down around a large table in the conference room. The director explained the plan to empower the staff to improve morale and the quality of care by implementing CQI. She also talked about the Day Rehabilitation staff member's role as the staff process action team. She then introduced me to the Project Enable staff. She said I was a county employee who would be administering the MTP and EMA questionnaires. In addition, she said I was a doctoral student interested in writing a dissertation about the implementation of CQI at Project Enable. The group appeared to greet me with warm curiosity.

After some pleasant remarks, I described the study, which would occur during the implementation of continuous quality improvement. I explained the importance of a qualitative case study of CQI, conducted from the perspective of the worker, which specifically addressed morale. Next, I explained "The Consent to Act as Research Subject Form" (Appendix B). Although I was not formally conducting my research at that time, I explained that participation was voluntary, and promised every effort would be made to protect the people participating in the study. The director chimed in and assured the team that anyone could withdraw at anytime. I also explained that my role would be that of observer, and explained the role of the Resource Development Coordinator as trainer and CQI advisor. Next, I explained the role of the director and the guidance team.

Then, I opened the discussion for questions. A few people asked questions about the study. I noticed that Diane appeared distressed and disturbed. Her arms folded, she was looking downward. At times, she sighed. I asked her if she had any questions or comments. She said, "I feel like I've been tricked into doing this!" I asked if others felt the same way. Ben spoke up. He reminded Diane that I had only asked them to participate in the study, and ultimately, it would be up to each individual in the group to decide whether to participate. I said that I understood how Diane felt. It is very difficult to separate the CQI implementation from the study. She seemed to calm down and smile a little after that. Most of the questions were about the extent of the time commitment. The director told them that it was up to them to set their meeting times. Although I offered to give them time to think about their decision, the entire staff unanimously agreed to

participate in the study. I had not received permission from the University of San Diego Committee on the Protection of Human Subjects to conduct research, but I had the participants read and sign the consent form, because I was county employee. Obtaining consent at this time was strictly a county risk management procedure.

Further discussion of how the study specifically related to the implementation of CQI and the Day Rehabilitation staff ensued. After a discussion that lasted about twenty minutes, the group decided that Friday afternoon would be the best time to meet.

When there was no further discussion about the study, I explained the "Motivation to Participate" (MTP) questionnaire and the "Employee Morale Assessment" (EMA) questionnaire. There were very few questions, so I administered the MTP and the EMA. After I collected the questionnaires, the director adjourned the meeting. The meeting was long, but the director and I felt it went very well. Overall, we agreed that the staff appeared upbeat and excited. I sensed that I had begun to develop a rapport with the group.

The Continuous Quality Improvement Training

On July 14, two weeks later, the director and the Day Rehabilitation staff participated in CQI training provided by Bill, the County Mental Health Resource Development Coordinator. Bill, a very dynamic personality, was introduced as the CQI trainer and CQI advisor for the implementation and the study. Bill has a brilliant sense of humor and tact. He seemed to instantly gain rapport with the group. He began the training by asking questions to assess what the participants

already knew about CQI. "Please write down the following questions. One, why are you here? Why are you in the business of treating the mentally ill? Two, what have you accomplished in your work? Three, what is quality? How is quality defined? Four, how is quality measured? Five, how are you involved in measurement? How is quality improvement accomplished?"

The participants were then given an opportunity to share their answers. One could have anticipated some of the answers given to question number one. Most of the participants said that they were in mental health because they wanted to help the mentally ill. Ernie said jokingly, that he worked in mental health because it was the only job in town. In reference to question two, all of the participants felt strongly that they had accomplished a great deal in working with the persistently mentally ill. The participants had rarely participated in measurement. They also had difficulty answering the question about defining and measuring quality, but seemed to feel that they intuitively knew when improvement had occurred.

For the training, Bill used a standardized CQI training curriculum that he developed in 1993 for county mental health clinicians (Appendix J). Based on my knowledge of CQI training, this curriculum was an adequate overview, but not nearly as extensive as many of the curriculums that I had reviewed in the literature. On the other hand, for four years, Bill had experimented with this CQI training curriculum and other techniques for training mental health clinicians. His training curriculum covered the benefits of high quality, a description of the quality improvement process, the definition of quality, how to identify the customers, how to identify suppliers and providers, the concept of teams, data-based deci-

sion-making, the Plan-Do-Study-Act process, and the seven quality tools (Appendix K). He also covered the continuous quality improvement steps; and, the guidelines for effective team meetings. The training ended with a group exercise. The staff process action team and the director seemed to enjoy this aspect of the training most.

For the exercise, Bill divided the participants into three work groups. He asked each group to identify a process in the Day Rehabilitation program that they would like to improve. Additionally, he asked them to discuss how to measure and chart the progress of improvement using one of the seven quality tools (Appendix K). The group broke up into three subgroups. Each group identified a process that needed to be improved. Then, after each group presented their findings, Bill helped them to identify the top three problems out of all the problems presented. The consensus was that improvement was needed in (a) staff supervision and training, (b) the relationship with families and the board and care providers, and (c) security.

After the exercise, Bill asked the same five questions he asked at the beginning. The group member's answers indicated that they had learned how to define and measure quality, and use the Pareto Chart. The training session ended with the staff completing a standard Resource Development Training Evaluation form (Appendix F). The trainees used the form to evaluate the training. Bill collected the evaluation forms, thanked the staff for their hard work, and invited them to call him if they had any questions about CQI. The staff remained and Bill departed.

The Initiation of the Continuous Quality Improvement Process

Next, the director addressed the responsibilities of Day Rehabilitation staff as the "staff process action team." She gave them the responsibility for selecting a team facilitator, identifying a process to improve, and obtaining consultation and training. After a brief discussion, the staff process action team reaffirmed that they would meet bi-weekly at noon, on Fridays. They planned to meet once during the holiday months of December and January. Also, meetings would be impacted by the fact that Cherry was planning to get married in February and would take some time off.

There was a pause in the meeting, so I took this opportunity to ask if there were any more questions about the study; and there were none. I reiterated that I would like to be invited to all meetings and offered to bring lunch to the next meeting. They graciously accepted the lunch offer, and the meeting adjourned.

On July 28, the next meeting took place. I decided to bring Church's Fried Chicken for lunch. I had the results of training evaluation, Motivation to Participate survey, and the Employee Morale Assessment. The staff seemed to be rushing to get to the meeting in the conference room of the Day Rehabilitation program. It appeared that they were having difficulty adjusting to the new schedule of meeting at noon. Shortly, we were all seated. The food was being passed around when Loren noted that Kentucky Fried Chicken is better than Church's Chicken. Diane, who was sitting across the table from Ben who was to my right, contended that El Pollo Loco was the best chicken because it was not as greasy as the others. I assured them that by the time the study was over, we will have

tried them all (Laughter). The director started the meeting after we served ourselves and then turned it over to me.

Researcher: "As you know, the purpose of this meeting is to present the findings from the CQI training evaluations, Motivation to Participate survey, and the Employee Morale Assessment survey conducted about two weeks ago. But, first I would like to discuss your selection of a facilitator and how the information from the MTP and the EMA survey relates to your strategy for identifying a process to improve. I would like to influence your thinking about your plans to select a facilitator and to identify a process to improve, then, talk a little bit more about my role in this process."

"There are some basic principles that I would like for you to observe as you go about your business as a staff process action team. As you look toward the selection of a process to improve, I would like you to consider the survey findings presented here today, as well as the problems that you identified during the CQI training exercise. But, keep in mind that you also have the latitude to select an entirely different process. The goal is to identify one or two processes to improve."

"Now, I would like to further clarify my role as researcher. My role is primarily that of observer. I would like to help whenever there is a question that I can answer. But please bear in mind that if there is a question, the team facilitator can consult with Bill, or Fay, or any other person. You will do most of the work. I will be a fly on the wall observing. I will attend as many of the team meetings as I can. After I get approval from the University of San Diego, Committee on the

Protection of Human Subjects, I will interview each of you individually and as a group. I do not know how long it will take to get through the approval process, so please keep good notes of your impressions. Also, I would like to have copies of all correspondence pertaining to the process. As a county employee, I am privileged to see this information."

Diane raised her hand. Diane: "Do you mean that we have to write everything down?" By the way she asked this question, she did not appear to like the idea of writing down everything. Researcher: "No, not everything. Write down just the things that are significant to you about the implementation of CQI and its impact on you or others." There were no further questions.

Researcher: "Now, let's talk about the facilitator's role. It will help the study a great deal, if the facilitator's role is limited to that of leading the group through the process." Ben jumped in. Ben: "You mean that the facilitator won't have a say?" Researcher: "No, that is not what I am saying. The facilitator's role is similar to that of the group leader in the CQI practice exercise. Whoever becomes the group facilitator, should bear in mind that their job is to facilitate, not to direct, or dominate the group. He or she is to make sure that everyone in the group has an opportunity to contribute. The facilitator must be careful not to impose his or her judgment, but to try to get all of the ideas out on the table. The facilitator is indispensable to the building of a consensus as to which problem you will want to tackle first. Once you decide on a process to improve, you will probably have to continue collecting data to substantiate improvement or the need for further changes. At the point that you have decided on a process to improve, you

should make a formal presentation to the director because she is the chair of the guidance team.”

Ernie raised his hand. Ernie: “What is the guidance team’s role?” Researcher: “First, as you already know, the guidance team is selected by the director only if necessary. The guidance team is responsible for approving the staff process action team’s proposal for process improvement. Second, the guidance team is responsible for providing support and the resources needed for the success of process improvement effort. And, there are certain ground rules for the director and the guidance team.”

“The guidance team must listen to the staff process action team’s proposal without interruptions or judgments. They may ask clarifying questions, but definitely not put down or argue with the presenters. The director, the guidance team, or both will receive the proposal, and within a reasonable period of time, respond with a yes, no, or maybe. In any case, responses to the proposal must be accompanied by an explanation or a request for the modification of the proposal. Another possibility is that guidance team can ask for more time. Finally, everyone has a commitment to communicate. This is one of the most important principles of CQI. Are there any questions?”

Jane raised her hand. Jane: “Can we bring in someone from the outside?” Researcher: “Yes, let’s say you would like to know something pertaining to patients. You can bring in knowledgeable patients and dialogue with them around your questions. If the problem involves the Socialization program for example, you might want to invite one of them to a meeting. On the other hand, the prob-

lem might be internal and administrative. In that case, you might then want to invite the director to a meeting. I'm particularly interested in how you communicate with the director. If there are no further questions, I would like to give the feedback from the surveys."

Researcher: "I am primarily interested in what you think of this data, so make comments or ask questions at any time. The training was given a group rating of 3.8 out of a possible 4.0 on the evaluation. Are there any comments?" None were offered. Researcher: "The results of the Motivation to Participate questions were quite interesting. Question one asks: What motivates your participation in this study? The responses were: Change may occur; Would like to help the researcher get degree; Sounds like a good study; I respect people working on a Ph.D.; I will be given time off work to participate in study [laughter]; I am interested in sharing information and ideas. Would anyone like to add or clarify this data?" Heads were shaking in the negative.

Researcher: "Question two asks: What are your expectations? The responses were: Management will listen and respond; Good study and; Poor follow through by management." Ben spoke up: "In the past, people have come through and asked a lot of questions, but nothing has happened as a result. Maybe that's why some responses are a little skeptical." Researcher: "Anyone want to add to that?" No one responded.

Researcher Observation

Here expectations were very modest as to the prospect of change occurring as a result of the implementation of CQI. Helping the investigator obtain his de-

gree seemed to be a strong factor motivating participation. I wondered if the propensity to help was a function of the fact that this group consisted of helping professionals. Also, many of them had in the past completed internships and written a thesis which meant they had to depend on others for help in completing their degrees.

Researcher: "Question three asks: What problems do you anticipate? The responses were: The truth may cause hurt instead of helping; Group unable to keep things confidential; Getting honest answers, and; Poor follow through by management." Cherry explained: "This group has a history of telling each other's business. So, I hope that when we are working on something, that no one goes and tells Fay about it before we agree on what we're doing." Diane interjected: "Yea, I think we should all be in agreement before we go to anyone." The group nods affirmatively. Researcher: "Are there anymore comments?" Silence.

Researcher: "Question four asks: What concerns do you have about the study? The only response was: Information may not be appropriately used." I took this opportunity to reiterate the fact that both the director and I were committed to protecting everyone involved in the study, and anyone could withdraw from the study at anytime without fear. Jane spoke up: "I don't think we are worried about you, its the people in the group." Ben chimed in: "I don't think we will have a problem with this. Usually, when we have a problem it is when its personal stuff. We know how to be professional when it comes to patient confidenti-

ality and other business such as this.” I asked if there were any more comments and there were none.

Researcher: “There was only one response to question five which asks: What kind of training do you think you will need beyond that discussed? The response was ‘Unknown’. The group had nothing further to add.

Researcher: “The results of Employee Morale Assessment are presented next. In presenting these results, I am going to report the average group score and then the normal range given in the author’s standard index for comparison. The first section in Part II asks questions about ‘your job.’ The group scored 70 on question one: How do you like your present job? A score of 70 is at the low end of the standard index range of 70-82 for this item.” Ernie commented: “Yea we like working here, we just need more money (laughter).”

Researcher: “On the second question, your group scored 60. Fifty-six to seventy-one was the normal range given on the index. Again, the group score was on the low end. It asked: Is the atmosphere of your workplace: A.-Extremely hot, cold, drafty, or dusty; B.-Usually unpleasant; C.-Occasionally unpleasant; D.-Generally satisfactory; or, E.-Excellent most of the time.” Cherry commented: “Working in the basement isn’t the best atmosphere (laughter).”

Researcher: “Question three asks: Is the lighting at your workplace: A.-Very bad; B.-Poor; C.-Just barely good enough; D.-All right; or, E.-Just right for the work to be done? The group score of 60 is below the normal range of 63-70 given for this item.” The director explained that lighting had been a long-standing

problem with the building. She also mentioned that the building was scheduled for renovation.

Researcher: "Question four was given a group score of 20 which is very low. The index range given for this item is 64-70. It asks: How about your ability to do your job? A.-I have a lot more ability than my job calls for; B.-My job doesn't make use of many things I can do well; C.-My job makes use of some things I can do well; D.-My job just about fits me; or, E.-I think I am where I now belong and that my present job will lead to a better one." The members of this group overwhelmingly felt their abilities were underutilized. Diane observed: "Most of the time we're on auto-pilot. But that has changed since we have been involved with the study. I feel energized." The other members nodded in agreement.

Researcher: "The group scored higher than average on question five which asks: For the most part, fellow employees in my department are: A.-Unfriendly; B.-Indifferent to me; C.-All right; D.-Cooperative; or, E.-Very friendly. The aggregate score was 90, and the range on the index was 77-88. Ben teasingly said: "Yea, we are one big happy family (laughter)."

Researcher: "Question six touched on a sensitive area. It asks: Compared to other pay rates in your office or plant, do you consider your rate: A.-Extremely low; B.-On the low side; C.-About right; D.-Above average; or, E.-Quite generous." Although the group score was 53, above the index range of 47-52, the majority of the members felt dissatisfied that they were paid on the low side compared to the county and Neighborhood House Association.

Researcher: "The issue of safety on the job was raised by question seven: How about the chances of your getting hurt on the job? This item was given a score of 53; 9 points below the lowest score of 62 given in the index range of 62-68 for this item." Cherry spoke to this issue: "We all agree that there are safety issues, but we don't agree on what to do about them. Some people want security guards and some don't." Ben: "This has a long history." Heads nodded in agreement.

Researcher: "The overall group score for Part II entitled your Job is 53. The index range given on this item is 62-68. Keep in mind small groups and service organizations tend to score higher on this assessment." No comment.

Researcher: "This next section in Part II is labeled 'the boss,' it refers to Fay (Fay smiles). Question eight asks: In attitude toward you personally, is your boss: A.-Always unfair; B.-Often unfair; C.-Sometimes fair, sometimes unfair; D.-Usually fair; or, E.-Fair at all times. The group score of 76 was in the middle of the range of 74-77." No comment.

Researcher: "A score of 100 is well above the index range of 68-70 for question nine which asks: If you have a complaint, how does your boss usually receive it? There was also comment written for this item: Fair, but no praise for individuals or group." The director just smiled, and there were no comments from the group.

Researcher: "Question ten asks: How well does your manager or supervisor keep you informed on company policy, plans, and developments? Here the group score of 60 is well below the range of 72-75." Silence.

Researcher: "Also, the score of 60 is below the range 62-68 for question eleven which asks: How well does your supervisor plan the work of your group." No comment, a few smiles.

Researcher: "Question twelve asks: How well does the supervisor explain new things to employees? A group score of 80 was given. The index range is 71-76." No comment.

A score of 46 was given to question thirteen which asks: How does your supervisor discipline employees who deserve it? The score of 46 is significantly below the range 69-74. The choices for this question are: A.-Bawls them out in front of other employees; B.-Uses sarcasm in front of other employees; C.-Is quite direct, but takes employees aside; D.-Criticizes in private and explains why; or, E.-Criticisms are always helpful and never given in the presence of others." Again, no comment.

Researcher: "A group score of 86 was assigned to question fourteen which is considerably higher than the average range on the index 72-79: This question is: I believe that my boss: A.-Is not qualified for the job; B.-Lacks some necessary qualifications; C.-Is fairly well qualified; D.-Is quite well qualified; or, E.-Is highly qualified. Although a score of 86 was given, there was also following comment: Highly qualified, but needs to work on 'B' above." No one cared to elaborate.

All scores when averaged for this section total 65.3. This group score is below the index range 70-74. As noted earlier, smaller organizations as well as service organizations tend to score higher on the EMA (quiet)."

Researcher: "The next section in Part II is labeled 'your company.' The questions are concerning employees perceptions of their company. Question fifteen asks: Compared with other employers in your community, how well does this company treat its employees? A.-Most others are better; B.-A few others are better; C.-About as well as average; D.-Our company is better than most; or, E.-Ours is decidedly the best. The group score of 53 was under the index range 62-66." No comment.

Researcher: "Question sixteen asks: Do you feel that the company: A.-Has little genuine regard for employees; B.-Looks upon them as workers rather than as human beings; C.-Gets by satisfactorily in handling employees; D.-Really understands employee problems; or, E.-Shows high regard for the employees' welfare. The group score of 50 was below the range of 62-68." There were no comments on this item either.

Question seventeen asks: In its relationships with the community, I believe our company: A.-Has built ill will; B.-Does not have the respect of the citizens; C.-Should do more than it has; D.-Has built some good will; or, E.-Has built a lot of good will. The assigned score of 70 is higher than the index range 62-68. "Cherry commented: Neighborhood House has a great reputation and so does Project Enable. They just need to pay a little more (laughter)."

Researcher" "The group score of 70 was given for question eighteen: When you tell your friends what company you work for, how do you feel? This item was given a score of 70 which is higher than the average range for this item, and seems to echo the sentiments expressed earlier."

Researcher: "Question nineteen is telling: In its relations between employees and management, I think the company is: A.-Doing a poor job; B.-Has considerable room for improvement; C.-About average; D.-Pretty good; or, E.-Decidedly outstanding. A group score of 46 was given. This score is below the index range which is 60-64." No comment,

Researcher: "The total of all group scores when averaged for this section is 57.8; below the index range 64-67. As noted earlier, smaller organizations as well as service organizations tend to score higher on the EMA."

Researcher: "Question 20 asks: Which one of the following in your opinion shows greatest consideration to employees: Answer 'A,' Your immediate supervisor, was most frequently chosen response." The group nodded in agreement. Diane: "We have to depend on Fay for everything."

Researcher: "Question twenty-one asks: Which one of the following in your opinion shows the least consideration to employees? Answer "C," top management of the company was selected by all."

Researcher: "Three answered 'A,' Poor, and three answered 'B,' Fair, to question twenty-two which asks: The care and maintenance given to washrooms and toilets is? As for question twenty-three: Two felt that the cleanliness of the lunch room was fair, and four felt it was okay. To question twenty-four: The food and vending machines are? One person answered 'A,' Poor, and 5 answered 'B,' Okay."

Diane replied: "The machines are out of order a lot!" Ernie: "Not lately!"

Researcher: "Questions twenty-five and twenty-six are not applicable because there is no cafeteria at Project Enable and Neighborhood House Association is non-profit organization. Question twenty-seven asks: What is your opinion of your company's method of inducting and training new employees? Two answered 'A,' Not enough attention is given to new employees, and four answered 'C,' They are being well treated and properly trained." No one spoke to this issue.

Researcher: "To question twenty-eight: How much do you think the company has to pay for hospitalization insurance for each employee annually? One person answered: 'D,' \$205.00 - \$250.00, and 1 answered 'E,' \$255.00 or more." Ernie commented: "I don't have any idea how much they pay for our benefits (laughter)"

Researcher: "To question twenty-nine: Do you feel that prompt action is taken on safety recommendations? Two answered 'A,' No, and four answered 'B,' Sometimes." Jane: "The safety issue was one of the issues raised in the training." Cherry: "I have a feeling that this will be one of the problems we will decide to solve."

Researcher: "To question thirty: Do you frequently receive orders from more than one person? Four answered 'A,' No, and two answered 'B,' Yes. To question thirty-one: If you answered yes above, do orders sometimes conflict? Two answered 'B,' Yes." No comment.

Researcher: "To question thirty-two: How do you feel about working over-time: Two answered 'A,' Do not like it at all." Ben commented: "We very rarely work overtime." There were no other comments.

Researcher: "Here are the comments that you made in Part III, 'Additional comments about your job:' High stress, low pay; Enjoy colleagues—keeps job acceptable." Loren: "That about sums it up!" (laughter). Researcher: "Next are 'Additional comments about your immediate supervisor:' I feel very comfortable with my supervisor. There is not enough confidentiality among staff." Cherry comments: "Sometimes, other people know more about your business than you do" (laughter).

Researcher: "Next are 'Additional comments about your company:' They don't really know us! They have little regard for working conditions and pay. Distant from program." Loren: "Historically, Neighborhood House Association, has been out of touch with us. I hope that will change."

Cherry: "This was a long meeting." The others agreed. Researcher: "Well, good job. I will give these results to the facilitator. All you need to do at this point is to set up the next meeting." The group agreed to meet in two weeks. I offered to bring lunch again, and the group agreed to accept.

Researcher observations

This was an interesting meeting from perspective of my sharing the results of the training evaluation, the MTP, and EMA with both the staff and the director present. These surveys were developed to share with staff and management. However, the atmosphere was tense and awkward at times. Especially when

covering sections concerning the supervisor and the company. This was to be expected because rarely do managers get feedback on their behavior from the subordinates. Overall, it was a good meeting, and I felt a sense of rapport developing with the group.

I ordered pizza for the next meeting which was August 11. I did not know what to make of it, but I noticed that the group members tended to sit next to different people each meeting. Loren, who had sat at the end of the table opposite me between Diane and Cherry, was now sitting on my right side next to Jane. Diane was now sitting at the end of the table between Ernie and Ben opposite me. I thought this note worthy because people are usually creatures of habit, and alliances among group members is usually stable. After we served ourselves pizza, Ben informed me that the group had chosen Cherry as the facilitator. I asked the group why she was chosen. Loren answered first: "Well I can give you my reason—because she's our office manager. I figured the core professional people, as far as counselors, would take on the issue of patient betterment or quality, and she would be the administrative position to facilitate the meetings. That's where I was coming from."

Diane cut in: "I didn't choose her (laughter). Researcher: "Can you elaborate?" Diane: "No!" (laughter including Cherry) Diane: "No, my rationale actually had nothing to do with Cherry, and everything to do with—you know? Usually when we do things around here Ben takes the helm. So, I was coming from that mind-set. I hadn't thought of dynamics or who does what with whom. When

we do something, Ben usually does it." Ernie: "I agree with Loren: "That's the same reason I picked Cherry."

Ben: "I had a different view about it. Any one of us could have done it. Because a lot of what we do she (Cherry) also has to do it. If we decide to pick a problem that has to do with safety, she also works here. If we pick a problem having to do with paper work, even treatment strategy, we have to tell Cherry to make sure so and so does that. So, I think any one of us could have the position she has now. On the other side, I think what we are primarily doing here is process. So it wouldn't matter who does it because we all have to be involved. I'm a little skeptical that anything that we do is going to make a difference anyway. We've already had a couple of things that happened that didn't mean jack. Last year we took a big survey. They brought in these outside consultants who said here's your problems. It didn't make any difference. I like to see Cherry included."

Researcher observations

Here I believe is a patent example of individual multiple constructed realities freely expressed within the group. I was impressed with the apparent open and honest dialog between group members. However, I was more struck by the fact that a previous top-down intervention had already taken place. Apparently, consultants had come in, conducted an assessment, and then given the group the findings. The fact that Ben had found the intervention useless seemed to confirm my belief in the general ineffectiveness of top-down interventions, insofar as im-

proving morale and increasing quality. In fact, the top-down approach appears, by this account, to have made Ben cynical.

A long discussion about the role of the facilitator followed. The group decided that Cherry needed to be a part of the deliberations, but her primary role was that of facilitator. The next topic was initiated when Loren asked: "Are we going to meet every day?" Diane railed at the thought of meeting every day: "I'm out of this if we're going to meet everyday. I'm sorry I can't give up all of my lunch breaks." Ben calmly intervened: "I don't think we can meet that often. The best time to meet as a group is on Fridays when Loren is here. I think we should meet in a couple of weeks." Cherry chimed in: "We can meet in between meetings to come up with a problem and an outline. This introduced the subject of the team identifying a process to improve.

Ben: "Lets identify a problem. We can meet on Fridays because Fay says we can get off at four to make up for the loss of our lunch hour. So, we should continue to meet at noon." Loren: "You can go ahead and meet without me because I'm only half-time." Diane: "It doesn't matter what your position is on the clock, you are an integral part of this team." Ben: "Individually anyone can drop out. But, we need to meet at noon. I have permission to let us off at four."

Researcher Observations

Here the issue of identifying a process to improve gets on the groups' agenda. Loren offered to let the group meet in his absence, but Diane pointed out that Loren was an important member of the team. This is ironic, especially because Diane had originally felt tricked into participating, and then later, threat-

ened to drop out if the group decided to meet daily. In addition, Ben reiterated that anyone could drop out of the study. From the perspective of group dynamics, the message here is “we are in this together—but, anyone can drop out?”

Ben: “We can start next Friday.” Loren: “Is it appropriate to talk about these things amongst ourselves during the interim?” (Cherry was looking at the researcher.) Researcher: “Yes, of course you can meet as often as you deem necessary. I will attend as many of the meetings as I can. I would really appreciate it if you will keep minutes of the meeting that I could not attend.”

Cherry took a vote and the team decided to meet in two weeks, and to identify a problem in the meanwhile. Jane informed me that the group would furnish lunch for the next meeting. The meeting adjourned.

Researcher Observations

The group dealt with the fundamental issues of why members decided for or against the facilitator, as well as their expectations of her. They tacitly agreed that it is desirable for all team members to participate, while giving individuals the latitude to drop out. The team revisited the issue of how often they would meet and agreed to meet every other week on Friday afternoon. My role as an observer was emerging and I felt that that the group had been comfortable with my presence. I was quiet for the majority of this meeting, although the group did look to me to answer the question of whether to meet between meetings. I was impressed by the fact that the group is consensus oriented and democratic.

Identifying a Process to Improve

August 25th was the next meeting. We had pizza for lunch, and everyone seemed to be smiling. As we served ourselves, there was talk about diets and losing weight. After the playful banter between Diane and Ernie, we settled down to work. Cherry called the meeting to order. During the break between meetings, the team decided that each member was to develop a list of processes they would like to see improved. Cherry appeared prepared and relaxed. Cherry: "How are we going to do this? Do we vote on each problem?" Ernie: "I'd like to start with the problem we came up with in the training: interaction with the community; families, and board and cares." Jane: "That's a big problem." Cherry: (preparing a list) "OK, improved relationship with the board and cares." Loren: "Once a month have a large staff debriefing on morale." Ernie: "I also put staff supervision and training down. And, I would like more mental health days." Loren: "I have mental health days down on my list." Ben: "I would like to look at problems with paper work." Ernie: "Put down pay." Diane: "I like that." Jane: "We're supposed to pick something we can do! Can we do something about pay?"

Cherry: "I already have some of these things down including the stuff from the surveys. So, let's try to vote on the ones we want to consider. OK, I have number one as pay, and security is number two." Ben: "Number three is training."

Diane: "We didn't consider one of the most important problems in the survey. There's a problem with confidentiality around here. When we get in trouble eve-

rybody shouldn't know before we get the message. Only you should know!"

Ernie: "I don't think that will ever happen."

Cherry: "I will add that to the list. Now we vote—before this is over we will try to tackle two problems. So we need to pick one now." Diane: "If we pick number one, we have to have people come in and talk to us about it." Ben: "I think whatever we pick, we have a way to go with it. The county pays about \$10 thousand more than we get paid for doing the same job. There is nobody looking out for us, and we serve the most difficult patients in the system. I would like for someone in Neighborhood House Association to go to the county and say we have good workers and we need to pay them."

Cherry: "OK, whatever happened to development of a more therapeutic program?" Diane: "I had that down too. Put that on the list. I think we need to talk about this, we need more materials. We also need to talk about our class schedule. We teach the same thing over and over." Jane: "That's right. Sometimes we're wandering around five minutes before class trying to think of things to do—and I'm guilty of this too. We do the same thing over and over because we've run out of ideas, or we don't have supplies. We need to be more structured is what I'm saying." Diane: "That requires more materials. We need a video library—like teachers." Jane: "That is exactly what I was comparing our situation to." Cherry: "We need to plan ahead." Jane: "I think we can do something about this. But, if we put pressure on Fay, she will get pissed. We need to voice our opinion in a respectable way. How would we begin to tackle

that? Maybe we need to let her know that as a group we need to be heard. I think that this is legitimate concern."

Cherry: "Lets take a vote. We have pay, security, confidentiality, communication with families and board and cares, staff supervision and training, debriefing on morale, more mental health days, and development of therapeutic program." (The group voted.) Cherry: "OK, it's pay and therapeutic program.

Which do we do first?" Ernie: "Pay!" Jane: "I don't think we can get it." Cherry:

"We will have to talk about this next meeting: "I think we did a good job. I offered to bring lunch to the next meeting and the group accepted. The meeting was adjourned: the group was cheerful and self congratulatory.

Researcher Observations

There was not a detailed discussion in the meeting about issues identified in the training or the Employee Morale Assessment survey. The three issues identified by the staff process action team and the director in the training (staff supervision and training, the relationship with families and the board and care providers, and security), made their list. However, of the many issues identified by the EMA survey, only pay and confidentiality made their list. For the researcher to raise the question of why the group did not limit themselves to the issues identified in the training and EMA in the context of their brainstorming might unduly influence the process. The question of why the group did not limit themselves to the issues identified in the training and EMA was explored in the individual interviews.

One of the recurrent issues in this group was the discrepancy between their pay and county employees' pay. They emphasize that the pay inequity has persisted despite the fact that Project Enable employee treat "the most difficult" patients.

Another issue that surfaced was the groups' anxiety about how the director would react to their proposal. However, they seemed to feel that they would be heard if they approached her respectfully. There was a lot of brainstorming and the team came to a rather quick consensus about their top two priorities. Brainstorming is the key to their consensus-based decision-making process. The democratic relationships, consensus decision-making, and brainstorming are dominant characteristics of this group. Clearly, the relationship among the members in this meeting is not hierarchical or authority-based. I really felt that I was a fly on the wall at this meeting. The members hardly noticed that I was at the table.

Money and Morale

The next meeting was September 8. I was running late, so called ahead and asked Jane and Cherry to pick up El Pollo Loco chicken for lunch. We quickly settled down, and after some remarks about the broiled chicken being much healthier than the fried chicken, the meeting got underway. This discussion centered on a pay raise for the team members. Ernie: "The money is in the contract." Ben: "It's not specific to salaries. Any moneys left over is mandated to go in specific areas. I don't know what we can do to change that. If you write

it up for the next fiscal year maybe they can put it in the contract.” Jane: “How would raises fit into performance, and quality of care, or morale?”

Ben: “I see your point. If we get a raise, that would only be a temporary fix. But, we would still be looking at the same problems that affect morale in the first place. If we were to stay with the thought of a pay raise, we would present it as a temporary morale fixer, or one in a number of ten things.” Jane: “I agree. If they came in and doubled our salary, in a few months there would still be things we might complain about. That would fix just that alone.” Loren: “Could we just ask for personal days off?” Ben: “Yea, but we already get two days.” Loren: “Could we ask to increase those to say four?” Ben: “If we do that we would have to go beyond Project Enable to Neighborhood House Association.” Loren: “We could probably ask for it.” Ben: “But, if they do it, they would have to do that across the board.” Loren: “They can’t do it for one specific program?” Ben: “No, if they give Project Enable people six personal days, they have to give everybody the same: “Loren. If we ask for a pay raise, won’t they have to give everyone a pay raise?” Cherry: “No, everybody is not funded through the same source.” Loren: “So, the pay and the day off is different?” “Cherry: “The pay is according to, I guess, who is funding the program. Now, as far as the personal-time, and comp-time, and annual leave, and all that; that’s across the board. Everyone accumulates twelve hours, everyone accumulates eight hours, and everyone accumulates two personal days.” Loren: “That’s what I wanted to know.”

Ben: “Ernie, you don’t have to answer this—is your hourly wage up there [another program] higher than your hourly wage down here?” Ernie: “Yea.”

Cherry: "Yea what?" Ernie: "Well, what they told me is 75% comes from here."

Cherry: "In other words, they didn't break it down?" Ben: "They're probably making more!" Diane: "So, what are we saying?"

Cherry: "Are we saying were not using pay?" Diane: "This is a complicated little issue here. It's not as simple as giving us more money (laughter)." Jane:

"That's what I said last meeting—nobody listened!" Cherry: "You did say that."

Ernie: "I think we should call around and see what people get paid for doing the same type of work." Diane: "They are going to go right back to the funding

source." Ernie: "We can compare the pay and the working conditions. We're paid less for conditions and the extent of patient needs compared to the county,

and within Neighborhood House Association." Loren: "What you would need then is an official paper that says what they make. You know what I mean?"

Ben: "We can call different people, but that's hear-say. You need to call somebody that says here's the break down of the people in the county; here's what

they make. You know, otherwise our data is suspect." Ernie: "We can call personnel at the county." Jane: "How long are we going to have to complete this

one problem? We've got to complete two problems. Do you think that in the allotted time, we are going to be able to tackle this? And, do you think that it's appropriate?"

Ben: "I see your point. If we are going to tie this into morale? I think that the other topic [therapeutic programs] is more appropriate. The money thing is a short term morale booster. That other thing we're talking about is a daily thing

that will go from here to whenever. So, that other one is more tied into morale than the pay is— for a longer period.”

Ernie: “Instead of tying it into morale, why not tie it into working conditions?”

Jane: “Because the study is about morale!” Loren: “Don’t we have more to say about the program than simply putting in for a raise? Certainly, I’m not saying we don’t need more money or that we don’t want more money, but I’m just wondering if it’s realistic in the time we have.” [Investigator: Sensing that the perception of the primacy of the study was limiting the groups decisions, I interceded to clarify]. Researcher: “The study is about the implementation of continuous quality improvement and its impact on morale. Whatever you think is important is fair game no matter what. The study is essentially about how you implement CQI to improve morale.”

Ben: “We would have to look at what other day treatment programs are paying for the same duties. And, we would also have to look at what other counties are paying.” Ernie: “Jane talked about quality. Does that mean your talking about environment, working conditions? Being down here in the basement is an issue for the patients. The working conditions are a morale issue for us—no windows!” Cherry: “So, are you guys saying we’re going for pay, or are we going to go with the therapeutic program?”

Diane: “How long is the study?” Researcher: “May or June 1996.” Jane: “I don’t think that’s enough time to process a pay increase!” Cherry: “And, everybody is going to be taking off in February.” Jane: “If we spend half the time on pay and half the time on therapeutic issues, with time off, that only gives us a lit-

tle over two to two and one-half months to deal with each issue.” Ben: “I think even more than that, this one your talking about [therapeutic programs] is more appropriate than a pay issue.” Cherry: “Yea, but we need two any way.” Ben: “Maybe we can move to the other one [pay] later. We have other issues too like, for instance, security and training. Maybe we can tackle one of those.” Jane: “Yea, security is a good one.” Ben: “We could add working conditions” (laughter). Diane: “It would be OK to scratch pay and move on to therapeutic program? Let’s take a vote on this.”

Cherry: “Would you guys like to vote? We really need to move on!” Ernie: “I say go for the pay. (Cherry took a vote and pay was defeated. Ernie was the only one that voted for pay. After the vote, Jane was the first to comment looking directly at Ernie). Jane: “It [pay] was too big—it’s a political hot potato.”

The meeting adjourned. I said that I would bring lunch.

Researcher Observations

From the perspective of the literature concerning pay and morale, an important discussion took place here. Although Ernie earlier fought for the pay increase, the group decided against it. The argument that there was not enough time because of the study, was just one of many reasons the group felt the pay issue was not feasible in my view. The group seemed to know instinctively that a pay raise would not have a lasting effect on morale. What happened is consistent with Deming’s view, which is that extrinsic rewards are not the workers’ primary source of motivation.

The issue of members limiting what they could do by the study was problematic. This mindset persisted even after I informed them that they could do anything they chose to do regardless of the study. The fact that the group continued to limit their plans to coincide with the study might be related to the members' initial motivation to help the researcher complete his dissertation. Though the study was interwoven into the pilot, it did not appear that the study influenced the groups' decision to vote down the motion to pursue a pay raise. As Jane pointed out to Ernie, the issue was probably too complicated because it was politically and practically difficult to pull off. Apparently, the influence of the study was an inextricable part of the process, but it was not a significant factor as far as the groups' decision on pay issue. The apprehension about being heard by the director probably weighed in as a greater factor. Finally, I believe the majority of the members wanted to say more about their program than putting in for a pay raise.

Developing a Therapeutic Program

The following meeting was September 22. Cherry called the meeting to order. Diane: "How are we going to develop a therapeutic program? What are the parameters?" Jane: "We need more materials, and a schedule or some kind of format that we would follow, so that if one of us isn't here, the person who is here would be able to have something to follow. It wouldn't be haphazard." Cherry: "We need a library." Loren: "We could use a video library!" Diane: "We need a library with videos and books." Cherry: "OK, so how do we go about doing this? I need to call Bill." Diane: "Why are we calling Bill?" Cherry: "We are going to

ask him what tools we can use that would be appropriate for this project." Diane: Tools for what? The charts you mean?" Cherry: "Yes." Diane: "Will he also tell us where to look for materials?" Cherry: "We can ask because he is a resource specialist." Ernie: "Why don't we take a look at what other programs are doing." Ben: "That is a good idea. We can start by getting a copy of other Day Rehabilitation program schedules, and call them about some of their specific classes." Diane: "OK, so we are going to call Bill. Are we going to call other Day Rehabilitation programs?"

Researcher: "What specifically is the project?" Cherry: "Development of a therapeutic program." Investigator: "When you say development of a therapeutic program, do you mean restructure the current program?" Cherry: "Yes." Ben: "We're talking two things. As Jane was saying—materials and restructuring. Are we going to do both or one?" Jane: "We have to know what kind of program we are going to have before we know what kind of materials we will need." Diane: "At this point, I don't know if we necessarily want to change any of our classes. We just need a whole lot more room to maneuver in terms of what we do. And, I definitely like the idea of when one of us is gone, we leave an outline for the substitute teacher. We don't have access to materials. The things that we have to do to get materials, doesn't seem too kosher."

Loren: "What I think about also is building a library. We would have tapes and materials here instead of having to run across town to Rosecrans to the county library." Diane: "I propose we have 'X' number of dollars every year to go and buy stuff." Loren: "There are a lot of resources out there if we had the

money. We will feel better to know that we have materials here. And, a lot of the material would be fairly inexpensive. We could have a very extensive library."

Diane: "And, if we do have to end up focusing on the videos at Rosecrans, we need time during our work day to go over and see what they have, you know?"

Ben: "They do have a catalog." Diane: "Who does?" Ben: "CMH" (county mental health). Cherry: "Well, we're out of time. Would you guys like to schedule another meeting in two weeks? Is there a possibility of visiting another Day Rehabilitation programs before we meet again?" Jane: "That is a good idea."

Cherry: "Well, maybe we should meet in three weeks. That would give us enough time. Meanwhile, I will call Bill." I announced that I would bring lunch, and the meeting adjourned.

Researcher Observations

Several interesting things happened during this meeting. Again, it is significant that when all was said and done, the staff process action team voted to better organize to improve the services for the mental health patients as a means of improving morale. This is consistent with the thesis that employees are intrinsically motivated by doing a good job as well as extrinsically motivated by pay. Related to this is the issue of belonging: another intrinsic motivation. There seems to be a high degree of cohesiveness in this group. For example, Ernie appeared to quickly get past the defeat on the pay issue and support the group plan to organize and improve patient services.

It is also noteworthy that Cherry decided to contact Bill to consult about the quality tools. Her behavior in this regard, was totally consistent with the plan to

use just-in-time consultation and training. Moreover, it is significant that she, as the facilitator, felt empowered to make decision to obtain consultation. However, there was no support from team members to pursue consultation about using the CQI tools.

At the October 13 meeting, the team settled down quickly to business after serving themselves the Chinese food that I provided for lunch. Cherry: "Bill would like to know when would be a good time for one of us to come up to the county mental health library to go over the video catalog?" Loren: "I have already been there several times." Ben: "Probably a Friday afternoon, because everybody is here." Cherry: "After we go to the library, then we can take a look at the schedule—isn't that what we're doing? Last meeting we discussed visiting the other Day Rehabilitation programs, but we weren't able to. Would you like to be the person who contacts them?" Ben: "I can. What I'd like to do first is to get a copy of their class schedule, so that I know what I'm scheduling people for." Cherry: "A copy of the schedule of?" Ben: "I'd like to have them FAX us a copy of their class schedule. I'd like to first go that way so I can have an idea of what we're going into." Cherry: "Anyone else have anything? (Silence) So right now we're just working with the outside providers." Ben: "I Just thought we would want to see what's out there first. So, we're going to contact the other people to see what they're doing, and also we were going to do some research on our own. We need to jot down what we're doing in our classes. We need to look at keeping the classes fresh. We may get some videos from Rosecrans, but looking at

fifty-two weeks in a year, we're going to improvise a lot. Some of it we will have to buy."

Loren: "I've got a place out in El Cajon I can get anything for ages from two to high school, and a variety of different types of magazines and books. Is this appropriate?" Cherry: "I think that it is appropriate. I just think when you buy materials you should get reimbursed for it. We also need to have some kind of log, so we will know exactly what is being taught, because I don't know how you guys do it." Loren: "For me it's not necessarily the same material all the time. So, I'm going to teach different kinds of word problems, puzzles, anything to make them think." Cherry: "Even if you wrote that down, it will help." Ben: "We might even take that idea a bit further, what we might want to do is have an individual folder of things so someone can jump in and teach a class. Because Loren may be teaching some step-five material that I won't know what to do with." Loren: "It would be good to get a larger supply of material—twenty bucks would fill up a shelf with paper." Ben: "Well, as far as that goes we do have a request for petty cash, but it hasn't come back yet. That would help. We can use some of that money for materials. But, anyway, that's a suggestion." Loren: "This is what I have been thinking of as far as what we're doing is developing resources. But like you said, it wouldn't be hard for me to write that out and provide the resources so that if I am out, you could teach my class."

Cherry: "What do you think about this Ernie?" Ernie: "Sounds good." Jane: "Did we talk about where we're going to get the materials from?" Cherry: "Yea, I talked to Bill, and he said just set-up a time that one of our people can go down

and spend about an hour reviewing videos in the mental health library." Jane: "We pretty much know what is there." Loren: "They do have a catalog." Cherry: "You don't think that is a good idea? So, you guys are not pleased with their material?" Loren: "No, its all right; it's just that we need a lot more." Cherry: "I also thought that we could call the Day Rehabilitation programs and have a contact person FAX over their schedules to us. We can then try to set up something where one or two of us can go and visit their programs and see what they're doing."

Ernie: "We should wait to see what their schedules look like" Ben: "I can make those calls; it would be coordinator to coordinator. I'm going to have to make the ultimate decision on who goes where and when." Loren: "I'd like to go visit one." Ben: "A lot is going to depend upon what we see when we get the schedules. We might find that we are far advanced. If we see something interesting we'll try to get you there." Cherry: "Do you think we want to do a survey of the patients to see what they want? Some patients complain about coloring all the time. Would that be too much to do the survey?" Ben: No, I think I still have some of those forms that we fill out every now and then. This is off the subject a little bit, but we need some time to do these things. I know of one video library store, but it takes time to go through those things."

Loren: "I go to a place called teachers' something in El Cajon, you can spend an hour there looking at materials trying to decide which materials are appropriate for which patients. It takes time. I think Fay allows socialization sometime to go get materials. They used to do that." Ben: "To some degree, it's not an

every-week-thing.” Cherry: “Can we do that? We would go look for materials. I believe if we’re going to act, we need to have time to go look for materials. It’s not an every-week-thing where we would get off early, but we would actually have to come back with something.” Ben: “I would have to be the judge of that. There are some things that we can do to save time like calling ahead to get a list. Then we can see if making the effort is worth it. If we take those steps initially, then if I need to go up stairs to ask for time or money, I can say here’s why!”

Cherry: “Right.” Loren: “We have to look at this material with a goal in mind. Is our goal to make them [patients] think? To focus on process, or employee coordination? Some things we’re going to have to get for the first grade level or special education because of that patient’s level of functioning.” Ben: “Right, I think the thing to keep in mind is primarily we’re treating the psychosis. You know that’s the first thing you have to look at is we’re treating psychosis. I’ve seen people come through here being very frustrated about so-and-so didn’t learn their times-table. That has nothing to do with it, you know, and I think anything we do that the primary thing is treating psychosis. If the major thing in class is to get someone to put their name on paper then you haven’t got the idea.”

Loren: “Yea, but I also see people like Richard, who three months ago, wouldn’t even look at a piece of paper.” Ben: “And yesterday he filled out a form by himself. I’m not expecting so much that we teach as to help the patient use what they’ve got. But, an answer to your comment is that we’re treating psychosis first, then everything else has to be worked off that. You know whatever it is we’re doing, we’re treating psychosis first. Sometimes, it’s more important to

keep Adrian awake than it is to teach." Loren: "If she gets the idea she gets a bonus" (laughter).

Cherry: "OK." Jane: "So what's next?" Diane: "We're done! I mean, until we get the schedules from the other programs, and Ben decides who is going down to CMH to check out the material." Cherry: "Are you guys plans for the future to change your outlines? How about a schedule that tells who teaches what classes. Are we going to get extra materials to teach the classes on the schedule?" Loren: "We should be looking for materials in the area that we are working." Cherry: "Yea." Diane: "It's two fold: number one, we need some variety in our classes; number two, we need to be able to have planning periods; and, number three, when one of us is gone, whoever is going to teach the class can go and pull out the teaching materials."

Cherry: "OK." Ben: "In the initial investigation, if I'm sending Jane down to CMH to look at the tapes, she's looking at everything appropriate to the program—not just her class." Cherry: "OK." Ben: "From there we look at individual classes." Loren: "Would it help if we all wrote up a summary of what we're doing in our classes?" (Silence then laughter). Jane: "A summary of what Loren?" Loren: "I was thinking it would benefit me to know what Ernie teaches in his class." Jane: "What have you been doing?" Loren: "I've been working on the process. To get people to use what they have and hopefully make some progress. If I have a person who can't write their name on the paper and I get them to write their name on the paper that's great. I think it's important to know what each other is doing. We know very little about what we all do."

Ben: "We had less of that when we used to all meet together. I think it's unfortunate that we stopped doing that." Loren: "I think it would be nice to have a summary of what we all do in our classes." Diane: (adamant) I know me! I'm not going to sit down and write a program. Can't we just look at the classes and tell what they are about?"

Cherry: "So, after you call the people and get the things (schedules) FAXED over, what is the time frame to set something up with them?" Ben: "We can probably do it within a week. So, at our meeting in two weeks we'll be able to log things down and look at it on paper?"

Cherry: "Then we can decide who goes." Ben: "Yea, whoever does go will come back with something. The only reason we can't (go visit a program) is because one, they can't accommodate us, or two, we can't get there because we're short handed. We do have a couple of days where people are going to training.

Ernie: "Maybe two weeks is too soon for our next meeting." Ben: "It might be; I'd like to get on it immediately." Cherry: "We also talked about doing a survey of the patients." Ben: "I have the survey and I'll pass it around so that if people want to make changes they can." Loren: "I know that 'B' group will want to have more smoke breaks. As far as asking them, what would you like to do? They will say I want to smoke." Ben: "What we will have to do is let them know that more smoke breaks is not an option. We have fifteen minute breaks between forty-five minute classes. I know they would like to have fifteen minute classes and forty-five minute breaks" (laughter). Jane: "So, lets meet in three weeks." Ben: "We have a holiday, so lets meet on—let's see we're having the

Thanksgiving dinner for the patients. . . Lets meet on November 20th. Cherry:
"OK, good meeting." The meeting adjourned.

Researcher Observations

This was a classical brainstorming session. There were several issues on the table. First, the issue of the San Diego County Mental Health Services Library as a resource for materials and videos. Several of the members were familiar with these library resources, and the consensus was that the program's needs exceeded the resources contained in the library. Second, Loren attempted to get each member to write down his or her class content. This idea did not get support. In fact, Diane inveighed against it. The group was, however, willing to look at the types of classes they offered.

Ben's authority role as coordinator surfaced during the discussion about the third issue, class schedules. Ben would have to get permission from Fay for the group members to take time off to visit other Day Rehabilitation programs. Therefore, he prudently advised the group that he would first ask the programs to FAX copies of their schedules to him so he could decide whether it was worth sending staff to visit. He let the group know that he would make the ultimate decision about who would go. Fourth, the team discussed visiting educational supply stores to examine teaching materials. Here too, Ben made the point that he would have to look at who would go look at materials, and required that members think in terms of the needs of entire program. Apparently, a requisition for petty cash had been submitted, but Loren felt he needed flexibility to purchase than the petty cash process allowed. A discussion about the goals of the program de-

veloped around this issue. According to Ben, the goal of the classes was to treat psychosis and not teaching per se.

Finally, conducting a patient survey is clearly an effort to determine the needs of the external customer. At the same time, in mental health, as in any service, it is necessary to place limits on what can be done to delight the customer.

Cherry called the November 20 meeting to order: "Jane, what did you come up with from Block Buster?" Jane: "Nothing, there is no list of videos. If you know the name of a video, you can look it up on the computer. The Chula Vista Library has a list of all of the videos that they carry, but they are not listed by category. You can't save a trip by getting a list because you have to pick out the videos that you need. Basically, you just browse. I also contacted the downtown library."

Cherry: "Loren, what did you find at the El Cajon store." Loren: "They've got a lot of material. I went in there and looked it through. I think that each one would want to go down because it covers many subjects. In that particular store, it would be a good place to go and browse. Things are quite inexpensive and a lot of the things are reprintable. If you buy something you can make copies of it and hand it out to your class. Looking at the catalog you can't tell what you want."

Cherry: "OK, Ben you said that you would call the Day treatment programs."

Ben: "I thought you were going to give me the names of the people to call."

Cherry: "I thought you were going to call, I could have been mistaken" (Silence).

Ben: "I forgot. But, we did do the patient needs survey" (Appendix L). Diane:

"Do you remember what they were most concerned about? Because in the af-

ternoon group they were concerned about having more movies, more outings, and more art." Ben: "OK, the movie, outing type answers, I threw out because that's impossible—what I did take was some of their ideas about how they were being approached here: some of the ideas about new classes, some of their reasons for coming; some of their reasons for not coming." Cherry: "What type of classes would they like to see more of?" Ben: "Cooking, they talked about horses. They wanted Ernie to do some stuff around scuba. A lot of people wanted more information about their illness, which is interesting. They wanted discussions about schizophrenia: why, how, and history. They wanted discussions around other people who have been successful."

Jane: "Sometimes I don't think they want to hear the truth about schizophrenia. They seem to want us to say: in five years their going to be well." Ben: "Maybe some of that, but it was also clear that they want to know more about their illness, and people in history who have had it and made some impact in life." Loren: In California, we have Erasing the Stigma. I think sometimes it is easy to dismiss what they tell us because we have problems during class; sometimes they're not compliant, and sometimes they're a pain. But, that doesn't mean that they don't have genuine concerns. It's funny that some of the things that they mentioned we talked about. A lot of the things that they talked about have to do with classes we have in place. The cooking classes aren't feasible because we need a kitchen. And, we need a constant supply of food." Diane: "In terms of them asking for more information about their illness, we have talked about it in the past. We might ask them what they mean. They are having a very difficult

time accepting the fact that they have a disease. It sounds like we haven't done our jobs effectively." Ben: "I think we need to be careful about saying we haven't done our jobs effectively. And, I don't think that is what they said in the survey. By the next meeting I will have the results." The next meeting was scheduled for December 8, I offered to bring lunch. The meeting adjourned.

Researcher Observations

It was interesting that although the results from the patient survey were not presented, the group had apparently been discussing the results with the patients and among themselves. Ben unilaterally decided to throw out the requests for more movies and more outings and this was not challenged by the group. Staff took seriously the patients' requests for more information about their illness and about people with mental illness who had been successful. The team continued to brainstorm about how to create a therapeutic program during this meeting.

I brought El Polo Loco chicken for lunch for the December 8th meeting. We passed around the handouts prepared for this meeting. Contained in the packet of handouts were the Results of the Patient Survey (Appendix L), Daily Activities Schedule for Southern Day Rehabilitation program, and the Daily Activities Schedule for the Heartfelt Day Rehabilitation Program. Cherry called the meeting to order: "Ben, did you bring the program schedules?" Ben: "Yes." Cherry: "Let's start by reviewing the patient survey."

Researcher Observations

Several things observed during the meeting were noteworthy. First, Ben presented and discussed the results of the results of the Patient Survey. Diane said

that she had tried the makeover class suggested in the patient survey, and the women patients responded very positively. Cherry called Erasing the Stigma the educational, support and self-esteem group; as a follow-up to the last meeting's discussion about ways to provide positive role models for the patients. She also requested literature from Erasing the Stigma which would be mailed.

The team decided to do the makeover class biannually, because it seemed to raise the patients' self-esteem. The consensus was that it was important to continue to look for ways to provide positive role models for the patients. They reaffirmed that they wanted Cherry to invite Erasing the Stigma to visit the program. Next, members talked about adding cooking classes, scuba diving, and horseback riding to the schedule. The patients had requested these specific classes in the survey. Members discussed the feasibility of providing the classes. They felt that they should reserve a monthly open-ended class slot for the above activities. Ernie who was a scuba diving instructor, and Loren, who was a horse enthusiast, both planned to bring in equipment as well as videos on the topics as an introduction to horseback riding and scuba diving. Ernie indicated that he could take a few of the patients to the bay for scuba lessons.

Next, Ben discussed the daily activities schedules received by FAX from Southern Day Rehabilitation program and Heartfelt Day Rehabilitation program. He asked the team to look it over and consider items that would apply to the restructuring of Project Enable's Day Rehabilitation classes and program. Ernie noted that one of the programs held its staff meeting in the morning, and liked the idea. Ernie: "Meeting in the morning might work after all is considered." How-

ever, there was no support for the idea of the morning meeting. The team did decide that it was necessary for one or two of them to go out and visit the Southern Day Rehabilitation and the Heartfelt Day Rehabilitation programs. Ben agreed, and assigned Ernie and Diane to go.

Cherry then clarified assignments: "Ernie and Diane will visit one Day Rehabilitation program. They will shadow the Day Rehabilitation staff as they proceed through their routine day, ask questions, and review relevant materials. Loren, Jane, and Diane will go to stores to examine educational materials for classes."

Diane motioned that the team implement the new program in January 1996. Cherry reminded the team that they needed to make a proposal to Fay before implementation. The team talked about various ways to make the presentation. They discussed who will write the proposal, and what will be included. Ben felt that the group could probably make many of the changes in the class schedules without going through a proposal process. The consensus was to see what class changes could be implemented by the next meeting on January 5, 1996.

Researcher Observations

The team has clearly begun to crystallize their ideas about how to create a therapeutic program that incorporates the desires of the external customer. The whole idea of going out to visit other organizations to learn more about how to improve is called benchmarking in the CQI literature (Brown et al., 1994).

Cherry called the January 5, meeting to order. (Diane had already distributed her handouts that included a price list of Edumate educational materials.) Loren: "Here are some materials (he displayed a number of books) that may be used in

teaching classes.” Ernie: “I visited Southern Day Rehabilitation Program in San Diego. I sat in on a 12:30 dual diagnosis group meeting. The group was interesting because the counselor called in sick and the patients ran the group. Their dual diagnosis group is for the dually diagnosed only. We mix our people. They [the patients] did a good job of running the meeting. Their building is much larger than ours is. They have three meetings going on at once. Their building is set up for security and privacy. Their furniture isn’t as nice as ours though.” Cherry: “What did you learn that we can use to better our program?” Ernie: The group is for the dually diagnosed only, and the patients run the group when the staff aren’t there.”

Jane: “I visited Education Supplies Plus in Chula Vista. I found lots of materials for the health classes ranging from pre-school to elementary school level. Mostly, there were books that we can use. They didn’t have any videos. Prices ranged from \$5.99 to \$15.00. There were books about independent living such as money management, building social skills, cultural games with workbooks, and some art materials. There were materials for the ‘A’ group [the higher functioning group] and the ‘B’ group. I liked some of the things so much; I started to buy them out of my own pocket. We need to be able to buy some of this stuff without going through the requisition process.”

Diane: “I visited Heartfelt Day Rehabilitation in El Cajon. They use the Feeling Good Handbook by David Burns to teach their classes. I explored how the handbook was implemented in the program. Like us, they don’t have a budget to purchase classroom materials. Their patients are higher functioning than ours

are. The program runs from 9:00 A.M. to 4:30 P.M. From 2:00 to 4:00 the patients are left on their own. Patients get to choose their own classes. There is a lot of construction in the area where the program is located. Some of the buildings are being torn down. In fact, they may have to move at some point. But the building is very large and they have a section up stairs where the patients can make pottery. The only thing I got was that Day Rehabilitation programs don't have their own budget for materials, and they use the handbook to teach classes."

Diane: "We need an immediate source of money to purchase things. I visited Edumate Educational Materials located in San Diego. I looked for materials that would meet the needs of all of our classes. They had posters that we can use for our Spanish-speaking patients. And since we celebrate "Black History Week," I found other multicultural material including 'Women's Month,' which is usually celebrated in March."

Cherry: Well we have done a lot of research. Where do we go from here? Last meeting we said that we could start improving the classes without going the proposal route." Ben: "Since we are running out of time, why don't we think about where we go from here, and discuss it in our next meeting." Cherry: "All in favor?" (Everyone agreed). Cherry: "We have a lot of things going on, so our next meeting is February 2nd. Everyone agreed, and the meeting adjourned.

Researcher Observations

Again, the idea of visiting other programs to develop ideas about how to improve the program is called benchmarking in the CQI literature. However, mem-

bers had seen little that they wanted to adapt from the programs they visited. The educational materials that were available at a low cost impressed them. The purchase of educational materials was tied to the notion of having a discretionary fund. This idea seemed to reverberate among the team members.

Developing the CQI Proposal

I brought deli sandwiches for the February 2 meeting. Cherry called the meeting to order: "I guess we need to decide what to do about the proposal." The group discussed how they were going to write the proposal and which members were going to make the presentation. Diane: "Who is going to make the presentation, one person or several of us." They decided that several of the members could present the proposal to the director on March 13, 1996.

The discussion then turned to the question of what to present. A discussion ensued. Diane: "We need to set up a library." The team discussed setting up the library. Ben: "We are now supposed to be doing rehabilitation in addition to treatment. To do rehabilitation we need to provide education." Diane: "Education is a large part of rehabilitation." Cherry: "So, we're going to do a proposal to buy books, videos, and other educational material to build a library." The team spent about twenty minutes discussing the cost of various items they estimated that they would need about \$1500 to accomplish the task. Diane commented: "They won't give us that much [money] at one time!" Other members agreed with Ben: that all that they could do is say what was needed to improve the process, and it would be up to management to decide if they can afford the items requested. Ernie: "We have to sit down and cost out all the items."

The group felt the priority was to start a library and request a \$75 revolving account to purchase educational material. The goal Diane said, "is to avoid the bureaucracy of having to submit a requisition every time we need something." "Often we can get items on sale," Loren concluded.

Jane raised the issue of allowing other programs access to the materials through a loan program. The team discussed the feasibility of a library loan program, and decided that they would need to establish a system wherein they could track and secure the materials. The consensus of the team was that they needed a lockable bookcase in order to implement a book loan program.

Finally, they revisited the format of the classes and decided that they did not need to propose any significant changes in the class format except the addition of a cooking class. They felt that they would be able to follow-up on the suggestions from the patient survey without going through the process of making a formal proposal.

The meeting concluded with the team agreeing that each would provide Cherry with data needed for her to write the proposal. They agreed on March 13, 1996 as the date to present the proposal to the director. The next meeting was scheduled for February 18. The meeting adjourned.

Researcher Observations

After eleven meetings, over a period of approximately seven months, the team decided on a CQI proposal for a library. A discretionary fund was needed to purchase educational materials for the library. The team also decided to request equipment and utensils for cooking classes. Moreover, they discussed and

implemented many routine changes that improved the program during this time. They instinctively knew what constituted routine changes and what were special changes requiring the approval of the director and the guidance team.

On February 15, Cherry contacted me and postponed the meeting scheduled for February 18. She indicated that there was a lot going on during the month of February and that it would be difficult to meet. She pointed out that the members would probably work on developing the proposal in the meanwhile. I asked her to check with the team members to determine if it was feasible to start the individual interviews in March. The University of San Diego, Committee on the Protection of Human Subjects was in the process of approving my request to do the study.

On March 13, the team had not met or developed a proposal. By the end of March, I received permission from the Committee on the Protection of Human Subjects to proceed with the study. I met and interviewed the director in late March. She indicated that she knew very little about what had transpired. She had literally been kept in the dark. The team had not treated her as one of their customers as expected. She was committed to participate in the process, but the team had not included her. This presented an interesting dilemma. She wondered aloud whether she should intervene. She quickly dismissed the thought, because she had promised the team control over the process. The team might have perceived her intervention as interference. Moreover, she was interested in what the team would do to solve problems. It took an incredible amount of discipline on her part, but she decided to wait until they were ready.

In April, I interviewed the staff process action team members. In the latter part of April Cherry met with the team and CQI proposal was completed. She scheduled the presentation of the proposal for May 9.

Presentation of the CQI Proposal

On May 9th the staff process action team met with the director to present the proposal. The director, Fay, and the staff process action team, Ernie, Ben, Jane, Loren and Diane were present. By all accounts, this was an important meeting for the team. Cherry called the meeting to order and gave Fay an overview of what had transpired in the CQI process. She also explained how the group arrived at their decision to develop a more therapeutic program. In addition, she talked about how each member of the group contributed by taking on assignments. She mentioned that they contacted Erasing the Stigma and planned for a presentation to the staff and patients. After Cherry presented the CQI Proposal (Appendix M), she asked Fay if she had any questions.

Fay: "I've only heard about a library and cooking classes!" Cherry: "We also discussed Loren bringing his horses over and doing a show and tell. But, we want the flexibility to enrich the classes." Fay: "You always had the flexibility to enrich classes, but I still don't see where your emphasis will be." Diane: "We want to revamp the existing classes. We want more hands on instructional materials." Cherry: "We will also make the library available to the other programs." Fay: "What are some of the other things you did—Ernie?"

Ernie: "I visited another Day Rehabilitation program. They only allow dually diagnosed patients in their patient run dual diagnosis groups. We let everyone

into ours.” Fay: “I am glad you guys have been looking at other programs, because I’ve noticed that you guys have been pretty apathetic. As far as having funds available at your leisure, we can’t do that. We all work for Neighborhood House Association! Basically, I’m putting it back on you. Neighborhood House Association will let you have only one petty cash.”

Diane: “So, we have to put in a purchase request?” Fay: “Yes, socialization is much more aggressive than you guys.” Cherry: “Is there a limit to how much we can request?” Fay: “Yes, and you need prior approval.” Ben: “I told you all we can always change our schedule. What we want is a fund to buy materials.” Diane: “The bottom line is that we’re not going to get those funds!”

Cherry: “All we need to do is make one big requisition. We will see what we can get approved.” Ernie: “We were told that Dr. Carey knew about the study. Why not present the proposal to Neighborhood House Association, and say that this is the result of our effort to implement CQI.” Diane: “This is what we want dog gone it!” Jane: “We can put in a requisition. It will work that way. This is what we want, but I don’t think that Neighborhood House Association will change their policy just for us.” Fay: “What is the bottom line of the proposal?” Ben: “We should invite Dr. Carey” (laughter).

Fay: “You guys spent a year to decide that you needed \$500 to spend as you want?” Ben: “We went through steps!” Cherry: “We did a survey” (outlined all of the process steps taken). Diane: “I didn’t use a lot of the stuff we were taught in the training because it just didn’t work for me.” Cherry: “Then we went to another plane.” Jane: “We had other concerns that we considered” (listed all of the

issues the group considered in the process). Fay: "After the credit line is denied, what is your next step?" (laughter). Cherry: "Put in a requisition; our patients really need more materials."

Fay: "I hear your proposal about books and videos which are passive activities." Ben: "The materials we were looking at are workbooks—things that we can copy." Ernie: "We can use a volleyball net. The one we have is shot." Fay: "That is something you can request." Diane: "We talked about Loren bringing in his horse stuff to do a show and tell." Fay: "How does that fit into rehabilitation?" Diane: "Sometimes we have to do things that are just fun." Jane: "One of things that the patients asked for is more outings, but I didn't think that that would fly. I thought that the socialization program would do that. I think the patients need more physical activities because they are getting fat." Jane: "I thought we would be discouraged from doing that because those things are more in line with what Socialization does."

Researcher: "Do you think it would have been helpful if Fay had been included in the meetings all along?" Diane: "It would have been beneficial to know what is or is not realistic. But, there may have been hesitation on my part as far as speaking my mind." Ben: "The reason we came up with this is because we were in the study." Cherry: "One of the reasons that Fay was not included was because people didn't feel that they could speak their minds. We were able to come together and act as a collective. So, we really had to discuss everything. Jane: "I think that we didn't want Fay. Here we were deciding what we wanted to do." Diane: "I don't think I fully understood the process. It wasn't that we did

not want Fay, it never occurred to me. I didn't think that we could consult. The process was supposed to be done in the meeting. Then we were suppose to present a proposal. You were excluded for a couple of meetings, so out of sight out of mind. CQI didn't work for us." Ben: "I know you [researcher] said that we could consult and get outside help, but I did not really hear you." Diane: "We didn't exercise our freedom." Ben: "It wasn't a conscious choice. Why didn't you [Fay] invite yourself in to the process?" Fay: "I thought you (staff process action team) didn't want me involved. I was most impressed with your going out and looking at other programs. I am looking forward to seeing how you use what you learned."

Researcher Observations

The director's question about it taking the staff process action team a year to decide that they needed \$500 to spend was to the point. The short answer to her question is that it takes a tremendous amount of time to make decisions by consensus. The group process is slow and many of the benefits and positive changes such as in morale and the quality of care are not readily perceptible. In fact, as far as process, the team had been quite successful. Some experts believe it takes ten years to implement CQI to the point that workers learn to work and learn together as a team.

At this point, the researcher was looking for a transition into the final stage of the study. Because of the two and one-half month period, that it took to develop and present the proposal, it was evident to the researcher that the study had effectively preempted the pilot. With the study coming to a close, the CQI initiative

momentum. This became evident in one of the individual interviews, which preceded the presentation of the proposal. I asked Ernie why he thought that the process stalled during the proposal development phase. He replied: "they think its over." Indeed the feeling in the group was that the study was over, and therefore, the CQI pilot had ended. I felt that this was a good time to stop and look at the data. I reasoned that the research could help to inform the direction of this CQI process in the future. I administered the EMA, which signaled the end of the study, and then formally ended the data-gathering phase of the study with the staff process action team and the director. They all agreed to be available to read dissertation chapters and for follow-up.

I spent six months writing, before the dissertation was ready for review by the staff process action team and the director. I kept in touch with the director and Cherry while writing the dissertation chapters. According to the original plan, review of the dissertation chapters by the participants was the final stage of the study. On December 7, I contacted Cherry and arranged to drop off a copy of the dissertation for the staff process action team to review. I also gave a copy of the dissertation to the director for review. I asked Cherry to check with the staff process action team members to schedule a follow-up and exit interview. I also contacted the director to arrange an exit interview meeting. It was convenient to schedule the follow-up and exit meetings at the same time. This brought the CQI study formally to a close.

Summary Discussion of the Implementation

The implementation of CQI at Project Enable was not a typical CQI process. It was a study of a short-term pilot in which the members of a self-directed team within an organization were given the responsibility for selecting their own facilitator and process to improve, and for obtaining consultation and training. Therefore, what transpired in this case can not be evaluated in terms of whether CQI worked or did not work. It can only be evaluated in terms of what can be learned. The purpose of this study was to obtain knowledge about how, from the workers' perspective, to implement CQI to improve morale in a community mental health center. It was also an occasion to implement CQI using the bottom-up approach. This effort was an attempt to implement CQI without the usual CQI standing committees, because eliminating standing committees is very important for programs with limited resources such as Project Enable. Moreover, the study was an opportunity to use and evaluate the findings of the Motivation to Participate and Employee Morale Assessment surveys.

The CQI implementation was designed to give the staff process action team the sole responsibility for selecting the facilitator and the process to improve, and obtaining consultation and training. This approach varied radically from traditional CQI implementation strategies. On the other hand, self-directed teams, quality circles, and the Clinical Staff Association have experienced relative success (bureaucracy excepted) using variations of the bottom-up methodology.

There is no right or wrong way to implement CQI or self-directed teams (Brown et al., 1994; Dobyns & Crawford-Mason, 1994), and little was known

about how to implement CQI from a non-bureaucratic, bottom-up perspective. Indeed, much of what transpired was influenced by the attempt to empower the workers and avoid the perception of a top-down process. Equally undesirable were standing committees and expensive training. By design, the workers were given the power to make critical decisions in clearly defined areas. Therefore, by design, management, the trainer and advisor, and researcher did not take a directive role in those defined areas.

The team did not seek out additional CQI training. They simply did not seriously consider it, and no one encouraged them to obtain additional training. The lack of participation by director was influenced by the fact that early on, the group agreed not to consult with the director until all was ready. This agreement was made in the context of the staff process action team's struggle to maintain confidentiality among themselves.

Over an eleven-month period, the staff process action team met independently to identify a process to improve, and to develop a proposal, which was presented to the director. The team successfully implemented CQI to improve morale. However, morale returned to baseline because the team did not seek consultation from the director or the CQI trainer and advisor. This resulted in a lack of training necessary to fully understand CQI or use the quality tools, lack of administrative support, and the lack of buy-in from management.

That is not to say that other events in mental health did not influence the morale of the staff process action team. Cutbacks, privatization, and managed care in San Diego County Mental Health Services had a dramatic effect. For exam-

ple, about one month before the administration of the final Employee Morale Assessment, the San Diego County Mental Health Director met with the staff to update them on the latest changes in the organization. She informed them of a possible \$20 thousand dollar budget short-fall, and of the definite plan to contract out the entire adult mental health system including the contract services such as Project Enable. This news had a demoralizing effect. Moreover, as might be expected, the demoralization was not limited to the staff of Project Enable. There was a parallel effect on morale throughout San Diego County Mental Health Services. For example, the Clinical Staff Association experienced a dramatic decrease in participation. The impact was so great, that in June 1996, the Clinical Staff Association had difficulty recruiting a nominee for the position of president-elect, as well as other officers. Nevertheless, it was the lack of training, consultation, and collaboration with management that caused the loss of momentum in this case. Finally, it became apparent that it would be impossible to protect the identity of the participants in this study. Therefore, the researcher obtained consent from each informant to publish this dissertation (Appendix P).

CHAPTER 5: FINDINGS AND ANALYSIS OF THE STUDY

Introduction

In this chapter, the results from the Motivation to Participate survey, the Employee Morale Assessment survey, the training evaluation, the description of the implementation (chapter four), and the Individual Interviews are used to address the research questions. The reader should bear in mind that the study of this pilot CQI implementation process is unusual in its almost exclusive focus upon the staff process action team's efforts. It was also unusual because of the lack of direct involvement by management. The reader should note that, though I characterize this implementation as unusual, there is no blue print for CQI. Pollit and Buckaert (1995) said about the use of the word "total" in total quality management (CQI): "If a concept includes everything, it means nothing" (p. 5). Senge (1990) acknowledges that building learning organizations is largely unexplored. Moreover, though CQI can build learning organizations, little agreement exists on the definition of CQI because a wide variation exists in the content, scope, and formality of processes in existence today (Glazer, 1994). Dobyns and Crawford-Mason (1994) wrote:

American managers at all levels and in all fields do not know how to manage

in this new global economy. . . . There is little public understanding of the need for quality management, little appreciation of what quality management could do for us, and little agreement on what quality management is. . . .

Change is required—dramatic change. Adopting the quality system of Dr. Deming requires a personal change so radical that Deming called it transformation, a change of state from water to ice. (pp. 51-52)

Though Deming spoke of radical change, he did not leave one-size-fits all blueprints. Moreover, this study only covers an eleven-month period. Phase I of a standard CQI implementation process can take “five years or longer” (Brown et al., 1994, p. 34). Therefore, in essence, this study is only a unique snapshot of the beginning of a CQI implementation process. The purpose of this study was to provide data on how CQI is implemented, specifically from the perspective of the workers, to increase morale. Usually, management selects the consultant the training, the facilitator, and the CQI process to improve. However, the literature and a need for knowledge influenced the design of this pilot CQI process.

Deming’s first love was statistical process control, but he was very committed to a unique revolutionary quality management philosophy. Ever mindful of the importance of the internal customer, the worker, he was noted for saying that workers have the right to enjoy their work. He emphasized the necessity for transformational change in management in order to bring quality into organizations. He frequently discussed how difficult and time consuming it is to achieve the level of change required to become a quality organization (Walton, 1986). However, studies of CQI from the perspective of the worker are rare. Indeed,

most of the CQI studies emphasize management. Dobyns and Crawford-Mason (1994) wrote: "Quality methods need just the opposite—fewer supervisors and the complete involvement of the worker" (p. 23).

One of the greatest challenges for organizations attempting to implement CQI, such as Neighborhood House Association, is to get managers to accept that success of the organization rests on the capabilities of the workers (Dobyns & Crawford-Mason, 1994). But, because the perspective of the worker is missing in CQI, we need studies from the workers' perspective. According to Lawler et al. (1992), significant improvements in performance generally do not occur until management relinquishes a significant degree of power to self-directed teams. Until that happens, true power has not shifted, and involvement are likely to be interpreted as tokenism.

Therefore, to avoid any perception of management manipulation, it was mutually decided that for this pilot study, the CQI worker would be given the sole responsibility for selecting a team facilitator, choosing which process to improve, and requesting training and consultation.

This model of implementation is similar to Seymour's (1993) infection or bubble up model which does not depend on top level commitment, but uses voluntary pilot programs to demonstrate success and then promotes the CQI philosophy through the organization by reference to those programs. This approach encourages individual and group initiative; however, it lacks commitment and leadership from senior officers that is so important to successful implementation.

The staff process action team functioned like a quality circle or an informal task process action team. Quality circles were discussed extensively earlier. Again, quality circles are groups of employees who voluntarily meet to identify problems and propose solutions. Quality circles are an essential component in the Japanese CQI method. Informal task process action teams are similar to quality circles. Informal task process action team members usually meet to identify problems and propose solutions. Informal task process teams inform management of problems, formulate solutions, and helps to implement and track progress.

Whatever the CQI process lacked, it made up for in terms of increasing our understanding of how workers can improve morale using the CQI process. In Addition, for future organizations: "Team learning is vital because teams, not individuals, are the fundamental learning unit in modern organizations" (Senge, 1990, p. 10). "The primary goal of the learning organization is to teach people to learn how to learn together (Senge, 1990). Despite shortcomings, the Project Enable staff process action team certainly demonstrated team learning.

The data below describes, in effect, the beginning of phase I of the CQI implementation process. Nevertheless, this data is vitally important because if the workers do not buy into the CQI process early on, the effort often fails completely (Brown et al., 1994; Milite, 1992; Payne, 1992).

The Research Questions

Question One

Research question number one asks: How is continuous quality improvement (CQI) implemented in a private-sector community mental health center? Because of limited resources, and the need to acquire knowledge about how specifically to implement CQI from the perspective of the worker to improve morale, CQI was implemented as a pilot study of the Neighborhood House Association, Project Enable Day Rehabilitation mental health program. As stated earlier, this was not a typical CQI process. To minimize waste, avoid top-down management initiatives, large numbers of CQI standing committees, and unneeded CQI training, the staff process action team was the only standing committee. They were given full control of their decision-making process in specific areas.

In order to avoid worker perception of a top-down management approach, nothing other than the Motivation to Participate survey, Employee Morale Assessment, and the initial CQI training were mandated. Thereafter, the staff process action team was given full responsibility for selecting a facilitator, identifying a process to improve, and obtaining consultation and training on an as needed basis. As explained earlier, the concept of the internal customer obtaining what is needed on an as needed basis derives from the CQI philosophy of just-in-time. Several interesting findings that pertain to question one are discuss below.

The Motivation to Participate Survey

In accord with the literature, before CQI was implemented, the researcher inquired about the participants' willingness and reasons for participating in the

study of CQI implementation. The literature is clear about the necessity to explore employees' motivation to participate in the implementation of CQI. Payne (1992) advises that when a CQI program is contemplated, one should ask what is the payoff for the workers to implement the program. In the same vein, Milite (1992) asserts that in order for CQI efforts to be effective, workers need to be consulted both individually and as a group, to determine their willingness to participate.

For the purpose of consulting with the workers, the researcher constructed a Motivate to Participate (MTP) questionnaire (Appendix C) that contained open-ended questions. The MTP questionnaire contains questions about worker's motivation to participate, expectations, problems anticipated, concerns about the study, and perceived training needs. The literature recommended that a party outside of the organization administer the survey. As an outsider, the researcher administered the EMA survey to the staff process action team members.

The Motivation to Participate (MTP) questionnaire, which was administered at the beginning of the pilot, was a good process tool. It helped the participants to engage in a productive dialogue about the CQI implementation, and it facilitated participant buy-in. The questions were framed in terms of the respondent's willingness to participate in the study of CQI as opposed to their participation in the pilot initiated by management. The researcher reasoned that framing the MTP questions in terms of the study would be less threatening to the respondents. The downside was that the researcher's high profile might have contributed to the respondent's mind-set that the CQI effort was entirely about the study.

I found that the responses pertaining to motivation varied among the staff process action team members. More than one participant was motivated because of an interest in helping the researcher complete his dissertation. Others were interested in the study of CQI. One person was interested in sharing information. Another respondent liked the idea of being given time off work to participate in the study. Finally, one person was interested in change.

I found that one of the benefits of consulting staff about staff expectations was that it gave everyone an opportunity to address concerns and ask questions. Member's expectations of what would result from their participation in the study varied. Several members expected a good study to result from their effort. One person expected that management would listen and respond. In contrast, another person expected poor follow through by management.

Under anticipated problems, one person anticipated that the truth might hurt instead of helping. Another person was concerned about confidentiality. A third person was concerned about the researcher not getting honest answers. Another member, again, anticipated poor follow-through by management. One participant was concerned that the information obtained may not be used appropriately. They did not know what additional training they needed other than that which was already planned. The issues of trust; trust among each other, and trust of the researcher came up repeatedly in the beginning.

The trust issue prompted the researcher to reassure the participants by promising the participants that they would have an opportunity to review and comment on chapters in the dissertation. The issue among the staff process ac-

tion team members was confidentiality. The group members were apprehensive that someone in the group would go prematurely to the director with information. Early on, the members of the staff process action team agreed amongst themselves that they would be confidential in this regard. This may have contributed to the director being left out of the process.

Overall, there was not a singular reason given as to motivation on the part of the informants. There were, however, some consistent themes. For example, later in the study, I revisited the issue of motivation in the individual interviews. I asked: What was your motivation to participate in the study in the beginning; and, why have you continued to participate in the CQI process? Ernie's response was representative of the practical side of the group: "I would say something different; to make a change. It sounded interesting: Fay, the boss, asked us to do it. It was done on company time and Fay gave us an hour off on Fridays."

Cherry's response represents the group's hope for a better relationship with management: "In the very beginning, I thought it would enable me to voice my opinion, to recommend changes, and hopefully see them become a reality."

Loren's response represents the group's curiosity and thirst for knowledge: "I always liked to further what I'm doing, to learn something I can use. Being academically brainwashed, I said let's see what it's about."

Diane's response represents the group's altruistic side: "To help you finish your doctorate." Finally, Ben's response typifies the group's global perspective:

"I was interested in the approach. And, with the monetary restrictions, I think we should look for new solutions; old ways no longer work, and, free lunch."

Employee Morale Assessment

The Employee Morale Assessment (EMA) was administered to the staff process action team at the beginning and at the end of the study. The questions in the EMA questionnaire elicited information about employees' opinions concerning their job, their supervisor, their company, and their work environment. The literature recommended that a party outside of the organization administer the survey. As an outsider, the researcher administered the EMA survey to the staff process action team members.

The EMA questionnaire that was administered at the beginning of the pilot was a good process tool. Because of the presence of the director, the group was somewhat subdued compared to subsequent meetings. Nevertheless, when the EMA results were presented, participants engaged in a productive dialogue with the researcher about the findings.

One of the reasons that I chose the EMA questionnaire for this study was to assess its strengths and weakness. First, Benge and Hickey (1984) advised the user to modify this questionnaire to suit the needs of his or her organization. I did this to a slight degree by not using Part I of the questionnaire. In the future, I would eliminate all of the irrelevant questions from the EMA questionnaire. This, in my opinion, would enhance the overall performance of the instrument.

Second, the effectiveness of the EMA survey were mixed. Overall, it did not seem effective in assessing morale at different points in time. In this case study

for example, the EMA is not sensitive to changes taking place in the environment. The impact of cutbacks and managed care in San Diego County Mental Health Services on morale in Project Enable were significant. About one month before I administered the final EMA survey, the Mental Health Director informed the staff of a possible \$20 thousand dollar budget short-fall, and the plan to contract out the entire adult mental health system, including Project Enable. This news had an effect the morale assessment outcome.

On the other hand, the EMA was useful in identifying important issues relevant to morale. For example, EMA question four showed that as a group, workers felt their ability exceeded what was required to do their job. It asks: "How about your ability to do your job? A.-I have a lot more ability than my job calls for; B.-My job doesn't make use of many things I can do well; C.-My job makes use of some things I can do well; D.-My job just about fits me; or, E.-I think I am where I now belong and that my present job will lead to a better one." This question was given score of 20 by the group. The standard score on the index ranged from 64-70. When the score for the above question was presented to the group for comments, Diane said: "Most of the time we were on auto-pilot. But that has changed since we have been involved with the study. I feel energized."

This is an example of but one of the critical issues related to morale as identified by the EMA. In addition, the EMA survey identified the workers' perceived issues concerning their relationship with top management, pay, work environment, and security. "They don't really know us!" "They have little regard for working conditions and pay." [Management is] distant from the program." "His-

torically, Neighborhood House Association has been out of touch with us. I hope that will change.”

The EMA also picked up the strong cohesion within the group, and the high regard for the director and for Neighborhood House Association. For example, in Part III on the EMA, under “Additional comments about your job,” the comments were: “High stress, low pay; Enjoy colleagues—keeps job acceptable. When this comment was read to the group, Loren commented: “That about sums it up!” (laughter).

The issue of pay came up repeatedly. Not only in the EMA survey, but also during the process of identifying a process to improve. The following excerpt was taken from that discussion:

The county pays about \$10 thousand more than we get paid for doing the same job. There is nobody looking out for us, and we serve the most difficult patients in the system. I would like for someone in Neighborhood House Association to go to the county and say we have good workers and we need to pay them.

What is interesting is that the team neither formally referred to, nor acted directly upon the EMA data in any substantial way. Instead, they brainstormed and negotiated among themselves.

The Continuous Quality Improvement Training

This CQI process was also unusual from the perspective of CQI training. Usually, the top executives receive a CQI overview, and middle management and employee receive extensive training in CQI. In this case, the staff process

action team and the director received one two-hour training. Subsequent training was supposed to be provided on a just-in-time basis. Neither the staff process action team, nor the director received additional CQI training after the initial training. In the individual interview, one of the participants, in retrospect, admitted that they could have used more training and advice, but they never considered obtaining it.

Based on the pre and post training discussions, the evaluation, and researcher observations, the CQI training successfully familiarized the participants with the fundamental CQI concepts and tools. The CQI training received an aggregate rating of 3.8 out of a possible 4.0 on the training evaluation. However, the team did not subsequently spend significant time attempting to apply the CQI concepts or the tools. Neither did the team spend a significant amount of time discussing the problems identified for improvement in the training exercise session. With the exception of the two times the facilitator mentioned contacting the CQI trainer regarding how to apply the CQI tools, the team did not refer to any of the concepts taught in the training.

Identifying a CQI Process to Improve

The staff process action team did not substantially consider or use the data generated from the Employee Morale Assessment survey. They did consider the three problems that the team identified in the training, however none of these was selected. Nevertheless, from the beginning, the workers involved in the CQI process was energized. Observing this process confirmed my belief that CQI can be implemented to improve the morale of workers. Diane stated: "Most of

the time we were on auto-pilot. But that has changed since we have been involved with the study. I feel energized."

Moreover, based upon what transpired, I am convinced that the workers in this case were motivated more by the intrinsic rewards of improving services for the clients than extrinsic rewards such as income, status, or safety. The team chose to create a therapeutic program over seeking a pay raise or improving security. Moreover, someone other than a person already possessing positional authority in the group, like the program coordinator or a senior clinician was selected as the team facilitator. One of the members thought that the program coordinator should have been selected as the facilitator, but she was the only one. Foremost among the reasons given for selecting a member who did not have positional power was that she was a valuable member of the team. Her selection may highlight and speak to the issue of the informal power structure within this group. This never talked about in the management oriented CQI literature.

Once the implementation was underway, the relationship that developed among the members of the staff process action team members was non-hierarchical and democratic. Meeting over an eleven-month period, the staff process team spent most of its time deliberating and assessing the program in order to identify a process to improve. The director was not consulted during this period. It took the team eight months for the staff process action team to decide on what specifically they would do to create a therapeutic program. Therefore, the group apparently was not looking for the approval of the director during this period. Approval from management is an extrinsic reward often desired by employ-

ees. In this case, group identity, and the idea of improving services, seems to be two motivating factors.

Left to their own devices, the staff process action team spent the entire time working as a unit, never once consulting with the director. The quality advisor was contacted twice, but he was not consulted about additional training. Once he was consulted about how to use the quality tools; and once he was consulted about resources for the classes. The process stalled in the proposal writing phase because, on the surface, the program got busy and the facilitator got married. Less obvious was that the group had grown dependent upon the facilitator to get things done. In addition, the group had grown to think that the CQI effort was about the study. They believed that the study was ending; therefore, that the CQI implementation was ending. This was, in my view, a result of the researcher taking on too much responsibility in the beginning. By administering the MTP and the EMA, by explaining most of the procedures, and by attending all of the meetings, I was viewed as the CQI expert. The researcher's behavior and the study contributed to the workers' confusion.

Through the use of brainstorming, the staff process action team considered a pay increase. They quickly decided that a pay increase was not feasible, and it would not result in a significant increase in morale. One of the members put it quite eloquently: "If we get a raise, that would only be a temporary fix. But we would still be looking at the same problems that affect morale in the first place."

However, the vote to drop the issue of a pay increase was not unanimous. The vote was four to one. One member felt strongly committed to pursuing the

pay increase because he felt that pay did affect morale. Nevertheless, once the group decided against him, he became just as committed to creating a therapeutic program as the others.

The staff process action team spent most of its time gathering data and discussing ways to improve the therapeutic program for the Day Rehabilitation patients. They used a consensus-based democratic decision-making process. With a good sense of humor, the group process resembled that of a self-organizing system described earlier by Senge (1990, p. 105). They appeared to place primary emphasis on being open to inquiry, self-criticism, and learning.

Exploring ways to create a more therapeutic program, they visited educational supply and video stores to look for interesting educational materials. They also visited other Day Rehabilitation programs. The team conducted a patient survey and incorporated the data from the survey into class changes. For example, the patients requested information about mental illness with an emphasis on people who have contributed to society. They also requested more outings, cooking classes, and show-and-tell on topics such as scuba diving and horseback riding.

After reviewing the survey, the program coordinator decided not to act on client's request for more outings. To my knowledge, this was the only time that the coordinator took unilateral action. Later, I discovered that activities such as outings were perceived by many to be the domain of the Socialization program. On the other hand, the staff process action team did, as a result of the feedback from the patients, change the class curriculum and contact Erasing the Stigma—an organization dedicated to elevating the esteem of the mentally ill.

Finally, the staff process action team developed and presented a CQI proposal to the director (Appendix N). The proposal requested funds to create a library and cooking classes. It was during this meeting that the team realized that it would have been better if they had involved the director in the process of identifying a process to improve. Based upon researcher observation, indeed, the staff process action team needed the director to be involved to help identify the process to improve and to steer the process. In my view, Diane stated the team's dilemma eloquently: "It would have been beneficial to know what is or is not realistic. But, there may have been hesitation on my part as far as speaking my mind." The director said of the process in the exit interview:

Initially, they were ambivalent. But, once they got started, they were pumped up. As they were going through the process, I felt that they did not want to let me know. As I later read through the draft [dissertation], I was surprised to find out how much they were doing. Every now and then, I would see something, or they would let me know that they met. I think they only let me know that they were meeting because they were telling me that they would be closing at four instead of five. But, I was basically kept in the dark. At one point, one of them was going to look at another program. I was amazed at how much I was kept in the dark! Not having a clue as to what was going on; when I got the proposal [CQI], and saw that they were requesting money, and kitchen utensils, and videos. I thought to my self: this is too much! This is ridiculous! I was a little annoyed because I felt that all that they had to do was ask me for the money. Everyone got angry at that meeting. Then I gave my

written response, and they haven't purchased anything to date. But, I think that they are waiting for the renovations of the building to be completed.

There has been a lot going on with the entire program moving into new offices.

In this case, it was realized by all that the director should have been part of the process, making suggestions, and offering resources. Whatever the reasons the director was not invited, this was one of the areas that has to be addressed if CQI is to be successfully implemented. It became apparent that it is impossible to implement CQI to sustain morale without management participation and buy-in. However, in the exit interview with the staff process action team, there was a consensus among the members that given an opportunity to do this process again, they would exclude management. They felt that they needed to meet alone in order to express their true opinions. They said that they would feel uncomfortable with management in the brainstorming sessions. On the other hand, they said that they would change the outcome. If they had to do it over, they said, they would want the proposal approved and to receive some acknowledgement from management.

After submitting the proposal to the director, the team took her advice and used the petty cash requisition process. The team eventually received two hundred dollars to purchase library materials. However, during the move to their new offices, the money was reallocated. The program coordinator, Ben, took part of the responsibility. He said that he did not spend the money fast enough.

"In an environment of constant budget cuts, you use the money quickly or you lose it."

In the final analysis, the system was back to status quo. The guidance team was not impaneled because the team used the requisition process. The original plan called for impaneling the guidance team after the staff process action team selected a CQI process and presented a formal proposal to the director. This plan was tended to eliminate the top-down, top-heavy bureaucracy usually associated with CQI efforts. Moreover, this was a version of "just-in-time committees." This design may have also enabled the status quo.

Question Two

Research question two asks: How do employees and the director perceive the specific experience of implementing continuous quality improvement (CQI)? The researcher's observations of the implementation (chapter four) provide insights concerning question two. Individual interviews conducted near the end of the CQI implementation corroborated the researcher's impressions. The researcher constructed the Individual Interview questionnaire to ask open-ended questions. The interviews explored with workers and the director (a) what resources and training were needed, (b) what motivated workers to follow through or not follow through with specific processes, and (c) what were the problems associated with the study?

The primary resource that the group used was autonomy and time. In addition to the two-hour training discussed below, the team used their time to meet, to visit two Day Rehabilitation programs, price and compare teaching materials,

conduct a patient survey, consult with the CQI advisor, and write the CQI proposal.

A two-hour CQI training at the beginning of the implementation was the only training provided. That is not to say that there was not a need for more training. Question four on the Individual Interview questionnaire asks: What did you like or did not like about the CQI training? Ernie: "It's a different concept. Meaning the old concept was military style, chain-of-command where you had to go to your supervisor. In the CQI concept, you can get together and do research and make suggestions about how to solve problems. It is a different way to approach the system to get things done as opposed to the traditional way. We learned how to improve quality, and we learned that what goes on in the trenches really affects the upper levels."

Based upon Ernie's response, the training was quite effective in getting across the philosophy underlying CQI. Here, Ernie eloquently articulates the principal idea of CQI associated with creating learning organizations that increase morale and the quality of service.

Cherry's response is less flattering. "Nothing! It was boring. I didn't like it. It shouldn't have taken all that time to do that training. It didn't apply to what we were doing. We can't use those tools—the different charts just don't fit."

The response of Cherry reflects her frustration with applying the CQI quality tools. She was not able to apply the seven quality tools taught in the training. In addition, apparently because of her frustration, she tends to discount the entire training. Specifically related to the quality tools, Individual Interview question five

asks: How compatible were the CQI tools (Appendix K) to your needs? As expected, perceptions varied, but after one training, most of the members did not find them useful. Ernie: "Very, we just don't use them." Loren: "I didn't think they were compatible. No way can we use those tools. We are dealing with real people and real issues. The tools are really not that useful." Diane: "I don't think that the charts were relevant—Confusing! Not compatible at all! If we are going to get people at the top to give us what we need, we have to make things as understandable as possible. If these tools are over our heads, we can't use them to make [management] understand. All we need to do is put together a good proposal." Jane: "Was I here that day? I don't remember." Ben: "Yes, I think they were. I saw nothing in the approach that couldn't be done." I was a little confused. I was talking to Cherry and she said she didn't see how the tools would fit into the proposal."

Without additional training and support, the team found the seven quality tools difficult to understand and to use in the implementation. What Cherry and the rest of the team apparently did not understand is that it takes more training to understand and use the quality tools. More important, these are great tools to analyze and to solve problems. If the team learned how to use the tools, Cherry might have been able to use them to present the findings of the team's brainstorming sessions. This would have been encouraging overall. On the other hand, people tend to equate disproportionately CQI with quality tools as compared to its philosophy.

Loren's response reflects an equation of CQI with the seven quality tools: "It sets up a pattern or schematic you can use on projects. It probably didn't impact me much. I got flow charts from it. I didn't apply it; it wasn't relevant. We were really using the professional expertise of the team members to improve quality. It [the tools] makes no sense."

Real change is difficult to accomplish at the small group level. Although brainstorming is a valued CQI technique, the team historically used their professional expertise to problem solve. However, the use of the quality tools would have constituted a change from the status quo to a different way of identifying and approaching problem solving. According to Senge, the quality tools are only 2 percent of CQI. Nevertheless, the tools are an important part of CQI. The use of the tools may be an indicator of change. The fact remains that no additional training was obtained. One of the main reasons that just-in-time training did not occur, was that the team might have looked to the researcher for direction, since he was involved in the first training. Another reason that additional training was not obtained might be related to the fact that the importance of the tools was not emphasized. Had the successful use of the tools been an indicator of success, additional training might have resulted.

Diane's response suggested tailoring CQI training to the participants' learning styles: "It was too detailed. I'm not a detail person. Sometimes all I need are the parameters. Next time I think he should hit all four social styles and leave it at that. I learned more when we got to practice the different ways of graphing, than when he was talking to us." In all fairness to Bill, he did incorporate the

training exercise into the session. However, an assessment of the participant's learning styles may be of value in formatting the training to meet the needs of specific group members.

Jane's response reflects how she valued the training and how CQI motivates the employees by getting them involved in their work. "Well I think it [CQI] gave us an opportunity to talk about things that concerned us. If we had not implemented CQI, I don't think we would have bothered. I had been hearing all of those initials for a while [TQM, CQI] and the training gave me a better understanding [of CQI]."

Ben makes an astute observation here. "We could have needed a lot more training, but we didn't think it was necessary." Indeed, the group and the program would have benefited from more training. Nevertheless, left on their own, the staff process action team did not obtain just-in-time training. Besides, how would they have known? Inclusion of the director might have led to the group obtaining more training.

Part "b" of research question "two" pertains to what motivated the workers to follow through or not follow through with specific processes. Accordingly, question two of the Individual Interview questionnaire asks: Why have you continued to participate in the CQI process? Ernie: "I didn't know I had an option." Ernie's response reveals that no matter how non-coercive management tries to be, the perception of coercion always seems to be operating in the background of the employee's mind. This phenomenon can be explained from at least two perspectives as articulated by Morgan (1986). He uses the metaphor of organiza-

tion as psychic prison, to explain how people in organizations become "trapped by their own thoughts, ideas, beliefs, or preoccupations originating in the unconscious mind" (p. 15). And, he also uses the metaphor of organization as instruments of domination, an extension of the political metaphor, to explain how behavior in organization can be understood from the perspective of how one group imposes their will on another group.

Cherry had a different perspective. "For me it was pretty interesting. We were in a cocoon. It gave us the opportunity to get involved and look around at different places. Besides, I like doing something new. It was a change of pace. When you do the same thing day in and day out, learning something new is great."

Loren's reason for continuing to participate in the CQI process was: "Because I said I would. Hopefully, we can develop a library with new materials." Diane: "It became interesting to me. As we began to talk about how to improve the program. It became exciting to think about what we can do." Jane: "I felt we were already committed. And, because there were some things we really needed to do. I hope we can make some changes." Ben: "Because they have to tell us why they say yes or no. That gives me a feeling of empowerment. That just makes more sense than giving a proposal and getting a flat yes or no. Even more, they have to try to get to 'yes' because its in the best interest of the patients. It's a very unique approach. It's not unusual to have a boss just steam roll over you. It was that way at my last job."

One of the issues was why the team did not spend more time addressing the issues identified by the Employee Morale Assessment. Individual Interview question six is an attempt to understand why the group did not spend more time on the results of the EMA. It asks: Why did you not pursue the issues raised by the Employee Assessment Survey? Ernie: (The only one who voted to pursue the pay issue). "Here, everyone knows what's important. At first we started to look at some of the issues that came out of the survey (employment and safety issues), but by the third meeting these things like pay scale and safety fell by the wayside. We went on to milieu issues." Researcher: "Why?" Ernie: "It just goes to show that there is a certain intimidation by management." Researcher: "But management was not there." Ernie: "I still think people are afraid."

Cherry's response was similar : "Because they know that nothing would ever come of it. We had a security guard before and we weren't going to get more money. We see the sickest most combative patients in the system. If we were going to get a raise we would have it already."

Loren: "I think we focused on quality of patient care. Maybe we realized that not much was going to change with our salaries. We hit reality. We looked at what we could change. Besides, we are in this profession to help the patients; and if we want more money, we can move on down the road. I have to say, I have never had a better boss than Fay."

Diane: "Because of a feeling of it not being safe to pursue those issues. We are horribly underpaid for what we do. We deal with patients that nobody wants to see. No fortune 500 company would want to deal with a patient who thinks

that that CIA is after him all the time. Maybe its not a pay thing. If we had the resources to do what we want to do for the patients, it would be OK."

Jane: "Because we decided to pursue the issues that we had the best chance of accomplishing. Given the time limits, it wasn't feasible—plus we would have to get a lot of people involved."

Ben: "I think it would have to do with the fact that we could readily impacted patient related issues. We thought maybe if we were successful, we could then try pay issues. Primarily, we have a better chance of success with a patient issue. So, I thought we may as well do that (patient issues) and go from there. If we pursued the pay issues and failed, would we want to pursue the next issue?"

The reason that the staff process action team did not pursue a pay increase has various explanations. Their decision makes sense in terms of the group's focus on intrinsic versus extrinsic rewards. Their decision also makes sense from the political perspective that obtaining a pay raise was not feasible.

Again, part "b" of research question two asks: What motivated workers to follow through or not follow through with specific processes. Question three on Individual Interview questionnaire asks: The process appears to have stalled temporarily at the point of writing the proposal; why do you think that happened, and, did you take any personal initiative to move the process along to keep it on track? Ernie: "I haven't done anything because it takes one, money; and, two, things are usually presented to Fay, and she directs it. And, things like the cooking class take money and some people have a negative attitude about it." Cherry: "So much was going on. Me getting married, others on vacation. But,

also trying to figure out how to use those tools didn't help. Then someone said forget the tools." Loren: "I haven't done anything. This is the way things go; waiting for the next person." Diane: "The group was supposed to get together and write the proposal and make a presentation using CQI on March 13th. But, we didn't have a point man or leader. We got caught up in Cherry's wedding." Researcher: "Weren't you the designated person in Cherry's absence?" Diane: "Yes, but I let it slip." Researcher: "Have you taken any initiative to get things back on track?" Diane: "No I have been waiting for Cherry."

Jane: "Probably lack of communication, procrastination. I left it up to the group leader. I asked her some questions about how it was going. I do think I asked her about lunch and called you at one point." Ben: "Because of our lack of experience, people busy with their personal lives. We had marriages, vacation, and the program. This was an extracurricular activity, not our main job. It was something above and beyond what we had to do. I turned in my project and periodically asked Cherry about it."

The process stalled for a several reasons. First, the group facilitator became preoccupied with her wedding. Second, the group viewed this process as an extracurricular activity. This might be another effect of the study. If this CQI effort was framed as a Neighborhood House Association, Project Enable effort, the workers may not have perceived it as extracurricular.

Third, the loss of momentum and frustration probably resulted because the team did not obtain consultation, training, or the administrative support necessary to fully understand CQI or adequately use the quality tools. Ultimately, the team

was demoralized because their proposal did not achieve the expected praise or buy-in from the director. It is typical, according to Brown et al. (1994), for the momentum generated during the initial phases of a CQI effort to wane: "Performance on most measures is essentially flat. Morale is down, and most employees perceive TQM to be just another program to deal with in addition to their regular work. Often this perception is reinforced by the organization itself" (p. 73).

Part "c" of research question two asks: What were the problems associated with the study? Individual Interview question seven asks: What were the problems associated with implementing CQI? An early interview with the director indicated that the experience of developing and proposing a pilot study for implementing CQI from the perspective of the workers was exciting. However, it was very frustrating for her to stand by as the implementation proceeded without intervening. She felt like she was kept in the dark for the entire period leading up to the proposal. This was problematic because, if she had been included, she felt she could have provided valuable input regarding resources and training needs. The director's observations from the exit interview are very astute:

I am not sure whether the staff understood their mission. If they did, they didn't know how to carry it out. Also, they were confused about the end result. When told that they couldn't have the fund, they wanted to go directly to Dr. Cary.

The workers did state in the exit interview that the only thing that they would change would be to involve the higher-ups. However, they only wanted to in-

volve them to make the decision to approve their recommendation, not the meetings. They felt that management's presence at the meeting would have stifled the process.

The team experienced other frustrations. Ernie was frustrated because he felt that the team had gotten side tracked at the end. When asked what were the difficulties associated with the implementation, he replied: "No follow through. People think it is over." Researcher: "But it is not over." Ernie: "The person that was assigned hasn't done any thing lately." The greatest frustration of Cherry was associated with applying the quality tools: "We didn't know how we could tie in the tools. This took some of our motivation away. Once we realized we could do it without the tools, we became interested again." Loren's response reflects the attitude that although CQI was a benefit, the effort was an extracurricular activity that takes a lot of time. He also expressed an attitude that other members have expressed at one point or another. He felt that he was doing his job as a clinician and that writing a proposal was something that perhaps management should be doing. "At this point of my understanding, it [CQI] takes time. This is like working on a MASH unit. Time may have been a problem. Going out to the stores took time. But, it contributed to the program. We were frustrated with the tools. It took time to write up the proposal. We needed someone higher up to write the proposal. We have to spend our time doing clinical work. Also, this is not an area of expertise that I think I want to learn. Maybe it is my age. I'm not looking to learn about proposal writing. Maybe I don't have the energy." Per-

haps if the director had been involved, she could have assisted the team in writing the proposal.

Diane's response highlights how difficult it is to understand CQI. Diane: "I'm not sure I fully understand CQI and apply the quality tools in a service organization. The tools haven't worked." Ben's response underscores how life and work tend to derail CQI efforts: "The long breaks between meetings. If we weren't doing this for a study, we would have had trouble getting things back on track. The vacations and the work with the patients make it difficult to meet. We tried all of the tools, but they didn't work. It was frustrating."

All of these responses highlight the fact that it is impossible to implement CQI to maintain morale, if management is not involved. Had the director been involved, she could have helped the staff process action team overcome all of the aforementioned obstacles.

Question Three

Research question number three asks: How is morale affected by the implementation of continuous quality improvement, as perceived by the employees and the director? Information from the Employee Morale Assessment, observations of the implementation (chapter four), and Individual interviews were used to address this question. The director sensed the group was initially ambivalent, "but, once they got started they were pumped-up." The responses by the employees to the second half of question two of the Individual Interview questionnaire also relates to this question. It asks: Why have you continued to participate in the CQI process? Cherry: "For me it was pretty interesting. We were in

a cocoon. It gave us the opportunity to get involved and look around at different places. Besides, I like doing something new. It was a change of pace. When you do the same thing, day in and day out, learning something new is great."

Loren: "Because I said I would. Hopefully, we can develop a library with new materials." Diane: "It helped us to dream about what we could do here at Project Enable. It put some energy in the group that we didn't have before. I think before we were on auto pilot. CQI was good, because it helped us to focus on what we could improve. Otherwise, it opened up communication and made us investigate some things that we wouldn't have otherwise. It gave us hope." Jane: "It became interesting to me. As we began to talk about how to improve the program. It became exciting to think about what we can do. And, because there were some things we really needed to do. I hope we can make some changes." Ben: "Because they have to tell us why they say yes or no. That gives me a feeling of empowerment. That just makes more sense than giving a proposal and getting a flat yes or no. Even more, they have to try to get to yes because it's in the best interest of the patients. It's a very unique approach. It's not unusual to have a boss just steam roll over you. It was that way at my last job."

The comparison of the Employee Morale Assessments taken at the beginning and at the end of the study, did not show significant changes. This may have occurred, in part, because the team was given bad news just before the second EMA was administered. Again, just before the second EMA was administered, the San Diego County Mental Health Services Director informed Project Enable staff of possible budget cuts due to a \$20 thousand budget deficit. She also in-

formed them that Project Enable would probably be contracted out some time in the future.

Overall, the CQI process improved morale and the quality of care in the Day Rehabilitation program. However, in the exit interview the team indicated that morale was at an all-time low because they were asked to do more with less and they lacked management support. They had not implemented a library or cooking classes because the money was used for other purposes.

Question Four

Research question number four asks: How is quality of care, as perceived by the employees and the director, affected by the implementation of continuous quality improvement? The director was very impressed with the team's efforts to meet the needs of the patients. Once the staff process action team got past the pay issue, the entire CQI effort was dedicated to improving the therapeutic program for the patients. In effect, the team's whole initiative was to increase the quality of care for the patients. However, in the exit interview, the team indicated that the organization was not taking care of them as well as they take care of the patients. To sustain quality in service organizations, the internal customer's needs must be met. Bear in mind that management is also an internal customer.

Question Five

Research question number five asks: How much staff and director time does the implementation of CQI involve? Including all meetings, it took a total of approximately one-hundred hours of staff time to implement CQI. The team was given an hour off at the end of the day on the Fridays when they held CQI meet-

ings. Individual Interview question eight asks: How much time have you spent above and beyond the meetings? Ernie: "Four hours. I went to Central Adult Day treatment." Cherry: "No longer than forty hours. It doesn't take long to make a few calls and type things up." Loren: "Three hours. Another hour thinking about it." Diane: "Four hours. I went to Heartland Day Rehabilitation Program. I found that they were just as strapped for funds as us." Jane: "Two to three hours, I went to the educational supply store in Chula Vista." Ben: "Every week I did something. About thirty hours. None of it was over time.".

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter summarizes the important aspects of the study and its conclusions. It also discusses its implications and makes specific recommendations. The chapter is subdivided into three sections: The Issue, Summary of the Literature, The Study, Conclusions, and Recommendations.

The Issue

Not since the industrial revolution of the late nineteenth century has society seen such dramatic change in both the workplace and within the workforce (Benge & Hickey, 1984). Heavy industry of the post-Civil War era dominated the United States economy for nearly a hundred years. The advent of the microchip jettisoned the nation from the modern, industry-based to what is commonly referred to as the "postmodern, information and service-based society" (Jensen, 1996; Walker, 1996). The workplace has shifted largely, in the last few decades, from the factory to the service organization. Correspondingly, the industrial workforce has changed, predominantly, to service personnel. Berry and Parasuraman (1992) advocate radical change in the way America's service organizations do business, because quality in service organizations is now

dependent upon interactions between the worker and the customer. The workplace of concern in this study is community mental health organizations, and the workforce encompasses the employees responsible for delivering mental health services.

Of essence in mental health, as well as any other service, is the quality of the service. High quality in service organizations requires satisfactory interactions on a one-to-one basis between the provider and receiver of services. Therefore, we must learn more about how to satisfy the employees in mental health services in order to improve the quality of patient care. Brown et al. (1994) wrote: "This approach is called 'the [external] customer comes second'. . . . To delight customers with exceptional products and services, the employee is the first customer the organization has to satisfy" (p. 95).

There are morale problems in mental health (Motenko et al., 1995), and case studies of the effect of CQI on morale from the perspective of workers are needed. Case studies have spoken to the effects of CQI on morale. For example, McLeod (1991), Glazer (1994), and others have written that the implementation of CQI improved morale in educational settings. Walton (1990) has conducted case studies of the successful implementation of CQI in a variety of industries including health care. However, these studies are very broad in scope, are not from the perspective of the worker, and do not address specifically employee morale.

Generally, the mental health literature is silent on the effect of the implementation of CQI on morale in community mental health organizations. Authors such

as Ray (1993) and Rago and Reid (1991) have written about the implementation of TQM in mental health, but employee morale was not addressed. The fact that high quality is being threatened by changes that lower morale forms the backdrop of this study. Changes in mental health care have affected morale, and it has been suggested that quality of service is greatly affected by low employee morale (Senge, 1991; Brown, et al., 1994). The question is how to improve morale in the face of rapid change.

Summary of the Literature

High morale among workers is crucial to quality in service organizations (Senge, 1990). Mental health services is in a state of crisis due to antiquated management practices and increasing health care costs (Rodriguez, 1989). Management consultants, such as Osborne and Gabler (1992), argue that privatization of government programs create private-sector learning organizations that are more responsive to customer needs while lowering costs. Historically, entrepreneurs making the case for privatization have claimed that government-operated programs are too bureaucratic and wasteful to lower costs and be responsive to customer needs (Dorwart & Epstein, 1993). Dorwart and Epstein conducted a national study examining the influence of government versus private-sector ownership on organizational responsiveness to the needs of a diverse mental health population. The study refuted part of the entrepreneurs' claims. There was no evidence that supported the claim that private-sector organizations are inherently more responsive to the needs of customers.

Moreover, they concluded that in non-competitive circumstances, "government agencies will in fact be more innovative" (p. 89).

Cost containment strategies have evolved in response to spiraling health care costs and poor quality. Alternative health service delivery systems, such as privatized-managed mental health care programs with spending limits, have gained prominence among the latest cost cutting strategies. In 1995, officials decided to contract most of San Diego's county-operated mental health programs, and, to convert its mental health system to managed care. The changes taking place in San Diego County Mental Health Services are not unique. These changes mirror changes taking place across the nation. A major concern about managed care is that quality of care may be adversely affected by job dissatisfaction associated with cutbacks, privatization, and managed care (Dumont, 1992).

Advocates of the quality movement have tried to reassure critics of managed care that managed care can cut costs and improve the quality of care. There has been progress in the discussions about morale and quality of care in the care-planning process. This is encouraging because, according to Senge 1990, the issue of morale is critical to quality in mental health service organizations:

Quality [in service organizations] is determined in individual transactions between 'servers' and customers, occurring literally thousands of times each day in large organizations. . . . It [quality] depends on how happy the server is and on whether he or she experiences the job as satisfying. (p. 333)

Motenko et al. (1995) examined the effects of managed care on the therapeutic milieu in a case study of patient and workers' impressions of cutbacks, pri-

vatization, and managed care in the Massachusetts's mental health system.

They found that:

Services were cut so drastically, that the therapeutic milieu was lost. . . . Social workers are not just overworked by new agency policies; their work environments violate the basic tenets of professional ethics. (p. 461)

The association between low morale and managed care among clinicians was also discussed by Williams and Torrens (1993). They found that dissatisfaction among physicians was highly associated with the fact that control over important treatment decisions was taken out of their hands by managed care. The findings of Motenko et al. pertaining to social workers' morale are significant. They reported that, "they were demoralized, but we did not expect the depth of demoralization we encountered" (1995, p. 461).

Dorwart and Epstein (1993) believe that although the issue of privatization and managed care is still widely debated, cutbacks, privatization, and managed care are here for the foreseeable future. Besides, the literature suggests that even if the funds lost to cutbacks are restored, demoralization would continue because of the top-down management practices. Williams wrote: "The question of whether to support or to oppose managed care may be less salient than the issue of how best to shape and participate in the processes of managed care" (1993, p. 200). The current debate must be approached from the perspective that improving employee morale is one of management's greatest challenges in creating and maintaining high quality privatized-managed mental health services.

The most important issues for the mental health service organization spans the continuum between how to cut costs and how to improve morale and quality of services. The literature suggests that learning organizations can address these issues. The literature also suggests that the implementation of CQI can create learning organizations in which improving morale, cutting costs, and increasing the quality of care go hand-in hand (Senge, 1990). Therefore, examining and evolving our view of organization to fit our current situation is the most important challenge to integrating cost-cutting with improving morale and quality of care in mental health organizations.

Review of the literature in organizational theory challenges the thesis that managed care is the problem. This literature suggests that poor morale and poor quality are associated with our out-dated views of organization and management (DeWitt, 1980). Specifically, it suggested that mechanistic views of management are the problem and not managed care per se. Morgan (1986) wrote that the metaphor of organization-as-machine best captures the current view of reality and describes today's industrial-era form of organization. The traditional, top-down, command-and-control oriented form of management characterizes the mechanistic organization. Morgan observed that the mechanistic metaphor was canonized in Fredrick Winslow Taylor's Principles of Scientific Management theory, published in 1911. Dobyns and Crawford-Mason (1994) wrote that Taylor's scientific management organized work so that a worker shall "do only one job exactly as she or he is told, with no deviation, no innovation, and lots of supervision. The mechanistic manager will typically exclude employees from organiza-

tional decision and policy-making processes regarding quality. In rapidly changing environments, mechanistic views of management causes alienation of the worker (Morgan, 1986). Historically, mechanistic views of organization have been challenged; though not with much success (DeWitt, 1980). The mechanistic view of organization as command-and-control remains dominant, even though it has long been highly associated with low morale among workers (Morgan, 1986).

Senge (1990) believes that in learning organizations "increasing quality and lowering costs can go hand-in-hand, over time (p. 65). But, he insists, the greatest impediments to adopting a new idea or a new approach "are the deeply held internal images of how the world works; images that limit us to familiar ways of thinking" (1990, p. 174). Senge calls these images mental models. Mental models can be simple generalizations or complex theories. Nevertheless, mental models are systematized conceptualizations of reality, which have a powerful affect on our attitudes and behavior.

Several underlying assumptions contribute to the perpetuation of the mechanistic world-view of management. Americans in particular have been conditioned to view management as an entity headed by a strong, autocratic, charismatic, man with the innate ability to command and control the people under him. This cultural stereo type suggests that the manager is an elite; entitled to receive the largest salary, and have the power to dictate what must be done and when. Greenleaf (1977) believes that this hierarchical view of management "is deep in our traditional wisdom, at least as old as the story of Moses" (p. 83).

More than ever before, organizations are finding it necessary to change. Ap-ropos, Dixon (1995) wrote: "It is increasingly recognized today that as organiza-tions face continuous change, they require the use of their collective intelligence" (p. 1). Mechanistic organizations are dysfunctional because they depend on the intelligence of a few at the top. Consequently, there is recognition of the need to evolve new forms of management practices based upon a different view of or-ganization. Dobyns and Crawford-Mason (1994) point out that by today's stan-dards, the mechanistic view of organizing is antiquated, and, "if we are to survive [and thrive] American managers must change what they think and believe" (p. 4). "In [industrial-era] quality manufacturing, the boss had to know it all and had to command and control the workforce" (p. 23). "The principle of separating the planning and design of work from its execution is often seen as the most pernicious and far reaching element of Taylor's approach to management, for it effec-tively 'splits' the worker, advocating the separation of hand and brain" (Morgan, 1986, p. 32). The Taylorian notion of management's role in organizations must be discarded.

The Japanese discarded Taylor's idea long ago (Dobyns & Crawford-Mason, 1991). Berry (1991) declared that: "TQM [CQI] is a management system whose time has come" (p. 1). To make CQI a reality, organizations must eliminate the mechanistic management system because it tends to breed anger, alienation, and apathy among the workers at the bottom of the organizational hierarchy; thereby lowering productivity (Odiorne, 1991). Because of the critical role morale plays in the performance of and the quality produced by a service organization,

managers must address employee needs if they are to invent and innovate ways to delight customers. Learning organizations are needed to address workers' needs. Therefore, the question is: how to create learning organizations? Senge (1990) wrote:

I believe the quality movement as we have known it up to now [in the United States] is in fact the first wave in building learning organizations—organizations that continually expand their ability to shape their future. . . . This can only be achieved by breaking with the traditional command and control, hierarchy where the top thinks and the local acts, to merge thinking and acting at all levels. (1992, p. 2)

Morgan metaphorically portrays learning organizations as organization-as-brain. Learning organizations can be created through the implementation of continuous quality improvement (CQI) (Brown et al., 1994; Senge, 1991). Continuous quality improvement is unique because it uses the collective intelligence of everyone in the organization to address costs, morale, and quality (Senge, 1991). The problem is that where CQI has been implemented, American managers have frequently ignored the worker's need to be included in the decisions. Deming, often dubbed the father of the quality movement, has been said to be:

deeply frustrated with the inability of American management to grasp the deeper message of the worldwide quality movement. . . . The deeper transformation starts with distinguishing "intrinsic from extrinsic motivation" and developing an organization where everyone, from top to bottom, is a learner. (Senge, 1991, p. 2)

Deming taught that traditional management cannot and does not get the best from any system (Dobyns & Crawford-Mason, 1994, p. 38). And, he emphasized the necessity for transformational change in management in order to bring quality into organizations. He frequently discussed how difficult and time consuming it is to achieve the level of change required to become a quality organization.

Deming is also noted for saying that workers have the right to enjoy their work.

The literature tells us that learning organizations can be created through the implementation CQI. However, one of the obstacles to using CQI to create a learning organization is a lack of knowledge about the worker. CQI can not be successful without worker buy-in. American managers would make the connection between CQI and learning organizations if they understood this simple axiom: "The first step for increasing quality is to find out what is on the workers' minds. If you can uncover workers' opinions of their supervisors, working conditions, and their job, then you can take action that will improve quality" (Benge & Hickey, 1984, p. 6).

Success of CQI is said to vary depending upon the context and the strategies employed (Brown et al., 1994). Studies have shown that the failure of America's CQI efforts is highly associated with the mechanistic management perspective, which does not include the worker in any meaningful way. If mental health service organizations are to thrive in the managed care era, they need to use CQI to create learning organizations that will improve morale and the quality of care. This can only be accomplished through the full inclusion and buy-in on the part of the worker.

Brown et al. (1994) reviewed the literature on the use of CQI and employee involvement approaches. A study of employee involvement approaches in 131 organizations over 30 a year period found that there are differences between the mechanistic approach, employee involvement, and CQI. Both employee involvement and CQI resulted in significant improvement, in terms of outcomes, over the mechanistic approach. However, the study concluded that the ideal approach would be to use techniques from both CQI and employee involvement. The down side according to this study is that although many critical problem-solving and group process skills were learned, quality circles and similar team problem-solving structures can have a negative impact on financial performance. Cumbersome committee structures and processes apparently increased costs and bureaucracy overall.

Nevertheless, the literature indicates that giving small groups of people high amounts of autonomy and direct access to customer demands often increases responsiveness and fosters innovation. More important, employee involvement may be superior where the work is primarily creative and the organization faces rapid change.

Because American CQI efforts are dominated by the mechanistic approach, there is an important knowledge gap in the literature. To date, there has been no research on the implementation of CQI in community mental health centers emphasizing workers' participation or the workers' perceptions of the implementation of CQI. Therefore, qualitative studies of the implementation of CQI from the workers' perspective are needed to fill the knowledge gap.

The Study

This dissertation focuses on a frequently neglected human dimension of continuous quality improvement (CQI)—the worker. The purpose of this study is to provide knowledge about the applicability of CQI with respect to the assessment, improvement, and maintenance of morale in a particular private-sector community mental health center. In the context of rapid change due to cutbacks, privatization, and managed care, it is essential to ascertain how workers in a private-sector community mental health center implement CQI, and to learn the impact on staff morale. This qualitative case study, from the perspective of the workers, of the effect of the implementation of CQI on morale, contributes to a knowledge base that was previously lacking. Such studies are necessary because the achievement of sustained quality in the post-modern mental health service organization is impossible without the enthusiastic participation of the worker. Low morale negatively affects worker participation, which in turn negatively affects the quality of services.

Since Phase I of a CQI implementation of can take five years (Brown et al., 1994), this study is in effect, only a snapshot of the beginning of the CQI process. The focus on the beginning of the CQI process is important because if worker buy-in is not accomplished in the very beginning, it usually does not occur.

A Motivation to Participate survey (MTP) was conducted at the beginning of the study to determine workers' motivations, concerns, and questions pertaining to the study of the implementation of CQI. In Addition, an Employee Morale As-

assessment (EMA) survey was administered at the beginning and the end of the study of the implementation. The purpose of the EMA survey was to gather descriptive data pertaining to the workers opinions about their job, their boss, the company, and the work environment at two important points. To avoid worker perception of a top-down management approach to this CQI effort, only the MTP survey, The EMA survey, and a two hour CQI training was mandatory for the staff process action team (Project Enable, Day Rehabilitation staff). The staff process action team was given full responsibility for selecting a facilitator, selecting a process to improve, obtaining training and consultation, and writing the CQI proposal. This implementation strategy resulted in the director's participation being limited, by the staff process action team, to the first two meetings including the training, and the meeting in which the staff process action team presented the CQI proposal.

The CQI implementation model used for this pilot study was similar to an informal process action team or a quality circle (Dobyns & Crawford-Mason (1991; 1994). The model used was also similar to Seymour's (1993) infection or bubble up model, which does not depend on top level commitment, but uses voluntary pilot programs to demonstrate success. This approach encouraged worker initiative; however, it lacked commitment and leadership from senior officers that is so important to successful implementation.

Essentially, the goal of this bottom-up CQI effort was to empower the employees of the Project Enable Day Rehabilitation program to identify and propose a solution to a problem that would increase morale. Emphasizing the workers'

perspective, the purpose of this study was to provide a thick description (Denzin, 1988; Spradley, 1979) of the CQI implementation at the Project Enable Day Rehabilitation program. The staff process action team met fourteen times over an eleven-month period. The perceptions of the staff and director were explored by researcher observation, in-depth ethnographic interviews, focus groups, and anonymous surveys.

Conclusions

This study sought to contribute knowledge by providing a unique perspective in CQI—that of the worker. It may be concluded from the findings that CQI was successfully implemented to improve morale. The workers worked together in a non-hierarchical, democratic manner to improve the quality of patient care. This indicates that CQI can probably create learning organizations. Below, Morgan describes a learning organization:

The work design was stimulated by the desire to create a holistic relationship between people and their work, so that employees would acquire a sense of identity with the firm and its products. . . . (1986, p. 104)

This case is a good example of how implementing CQI is a way of structuring adult development and building learning organizations. The primary goal of the learning organization is to teach people to learn how to learn together (Senge, 1990). This means the group; not the individual is the focus of attention.

However, although the morale of this self-directed team was improved by the implementation of CQI, this case demonstrates that it cannot be maintained without the collaboration and support of management. In addition, because man-

agement was excluded from the process, the workers did not obtain additional training and consultation needed to fully understand CQI and use the tools. Ultimately, the staff process action team did not get buy-in from management and morale returned to baseline. The study attempted to answer five questions regarding the effect of implementing CQI in a community mental health center. Below is a discussion of the five research questions the study attempted to answer and conclusions:

Research question number one asks: How is continuous quality improvement (CQI) implemented in a private-sector community mental health center? As stated earlier, this was not a typical CQI process. The staff process action team was the only standing committee, and they were given full control over the decision-making process. Management did not direct the team; and, given the choice, the team did not consult with management during the implementation. However, this is not to imply that there are blueprints to CQI implementation. Pollit and Buckaert (1995) wrote about the use of the word "total" in total quality management CQI: "If a concept includes everything, it means nothing" (p. 5). Also, Senge (1990) acknowledges that building learning organizations is largely unexplored. Moreover, though CQI can build learning organizations, little agreement exists on the definition of CQI because a wide variation exists in the content, scope, and formality of processes in existence today (Glazer, 1994). Dobyns and Crawford-Mason (1994) wrote:

There is little public understanding of the need for quality management, little appreciation of what quality management could do for us, and little agreement

on what quality management is. . . . Change is required—dramatic change. Adopting the quality system of Dr. Deming requires a personal change so radical that Deming called it transformation, a change of state from water to ice. (pp. 51-52)

Though Deming spoke of radical change, he did not leave one-size-fits all blueprints.

To acquire knowledge about how specifically to implement CQI from the perspective of the worker to improve morale, CQI was implemented as a pilot study of the Neighborhood House Association, Project Enable Day Rehabilitation program. The goal was minimize management's role to encourage worker initiative and buy-in. Because of limited resources, and the need to minimize waste, this effort sought to avoid top-down management initiatives, large numbers of CQI standing committees, and unneeded CQI training. In order to avoid worker perception of a the top-down management approach, nothing other than the Motivation to Participate survey, Employee Morale Assessments, and the initial CQI training was mandated. Thereafter, the staff process action team was given full responsibility for selecting a facilitator, identifying a process to improve, and obtaining consultation and training. The concept of the internal customer obtaining what is needed on an as needed basis, derives from the CQI philosophy of just-in-time.

Foremost among the conclusions is that the implementation of CQI can improve morale. However, unless workers and management collaborate, morale cannot be sustained. Meeting over an eleven-month period, the staff process

team spent most of its time deliberating and assessing the program in order to improve the quality of patient care. It took the team eight months to decide on what specifically they would do to improve the therapeutic program. After a lot of hard work, the team was demoralized in the end because they did not get buy-in from the director. They did not consult management during the process.

There were various reasons given by the team for not including the director. Here, are a few. "It would have been beneficial to know what is or is not realistic. But, there may have been hesitation on my part as far as speaking my mind." "One of the reasons that Fay was not included was because people didn't feel that they could speak their minds. We were able to come together and act as a collective. So we really had to discuss everything." "CQI didn't work for us." "I know you [researcher] said that we could consult and get outside help, but I did not really hear you." "We didn't exercise our freedom." "It wasn't a conscious choice." I asked the director why she did not invite herself in to the process?" She replied: "I thought you [staff process action team] didn't want me involved."

In the exit interview, the team said that they would exclude management in a future CQI implementation. They felt that they could not speak their mind with management there. The issue of how to get workers and management to collaboration is the most important area to address, if CQI is to be successfully implemented to improve and maintain morale.

The Motivation to Participate survey, Employee Morale Assessments, and the initial CQI training was mandated. Thereafter, the staff process action team was given full responsibility for selecting a facilitator, identifying a process to improve,

and obtaining consultation and training. These were essential components of the implementation. The following discusses what was learned about their effects on the implementation of CQI.

The Motivation to Participate Survey.

The literature is clear regarding the need for management to inquire about participants' willingness and motivation for participating in the implementation of CQI (Payne 1992). Workers need to be consulted both individually and as a group, to determine their willingness to participate in the CQI implementation (Milite, 1992). The Motivation to Participate (MTP) questionnaire (Appendix C) used in this study, was constructed by the researcher and contained open-ended questions about worker's motivation to participate, expectations, problems anticipated, concerns about the study, and perceived training needs. The MTP questionnaire, was administered at the beginning of the pilot, and was a good process tool. I found that one of the benefits of consulting staff about their expectations is that it gives everyone an opportunity to address concerns and ask questions. It also was an icebreaker and helped the participants to engage in a productive dialogue about the implementation of CQI. Moreover, the MTP facilitated participant buy-in. I found that the participants' responses to being consulted varied. Member's expectations about their participation in the study ranged from "a good study, "to the expectation there would be "poor follow through by management." The fact that informants' perspectives varied supports the postmodern constructivist belief that group reality consists of multiple constructed realities. Although there was no singular motivation, there were some consistent themes in the

responses. When I revisited the issue of motivation in the individual interviews. I asked: What was your motivation to participate in the study in the beginning; and, why have you continued to participate in the in the CQI process? I found that participants had practical reasons. One informant was motivated by the prospect of doing "something different." Another was motivated because they wanted "to make a change." Another was motivated "because the boss asked us to do it." And, finally, another because "it was done on company time; and Fay gave us an hour off on Fridays." I believe these responses resonate to a degree among all group members.

Other reasons given were hopeful. One respondent hoped for "a better relationship with management." The hope to be heard was illustrated by this response: "In the very beginning, I thought it would enable me to voice my opinion, to recommend changes, and hopefully seeing them become a reality."

Still other responses represents the group's thirst for knowledge and altruistic side: "I always liked to further what I'm doing; to learn something I can use. Being academically brainwashed, I say let's see what it's about." "I was interested in the approach. And, with the monetary restrictions, I think we should look for new solutions. Old ways no longer work; and, free lunch." One respondent's main reason for participating was: "To help you finish your doctorate. "

Although the literature recommended that a party outside of the organization administer the survey, who the party is, makes a big difference. The fact that the researcher administered the MTP and explained the procedures of the study

apparently influenced the participants' perspective about the process. They persisted in thinking of the CQI implementation in terms of the study.

In conclusion, the MTP survey was a good process tool and it did acquaint the researcher with the multiple constructed realities within the group. This helped the researcher to ground his theories in the group reality. Having an understanding of the group members' perceptions concerning their motivation, expectations, concerns, and questions, increased the likelihood of achieving and sustaining participant buy-in.

Employee Morale Assessment.

The literature recommended conducting an employee morale assessment on a regular basis. Benge and Hickey's (1984) Employee Morale Assessment (EMA; Appendix D) was used to conduct an employee morale survey on the team members at the beginning and at the end of the study. The questions in the EMA questionnaire elicited information about employees' opinions about their job, their supervisor, their company, and their work environment. The literature also recommended that a party outside of the organization administer the morale survey. As an outsider, the researcher administered the EMA survey to the staff process action team members.

The EMA questionnaire administered at the beginning of the pilot was a good process tool. Although somewhat subdued compared to subsequent meetings, (apparently because of the presence of the director) when the EMA results were presented, participants engaged in a productive dialogue with the researcher about the findings. Nevertheless, the team neither formally referred to, nor acted

directly upon the set of EMA data, in any substantial way, in subsequent meetings. Instead, they brainstormed and negotiated among themselves. The team might have benefited from a formal review of the results with management.

In conclusion, one of the reasons that I chose the EMA questionnaire was to assess its strengths and weakness. First, Bengue and Hickey (1984) advised the user to modify this questionnaire to suit the needs of his or her organization. I did this by not using Part I of the questionnaire. In the future, I will eliminate all of the irrelevant questions from the EMA questionnaire and add some questions of my own. One of the difficulties with the questions in this instrument is that they are hierarchical in orientation. The hierarchical perspective of the instrument is not consistent with the model of CQI promoted here. These revisions, in my opinion, would enhance the overall performance of the instrument.

Second, the effectiveness of the EMA survey was mixed. Overall, it did not seem effective in assessing morale at different points in time. I say this because the EMA was not sensitive to changes taking place in the environment. The changes taking place in San Diego County Mental Health Services were significant. I have already mentioned that before I administered the final EMA survey, the Mental Health Director informed the Project Enable staff of a possible \$20 thousand dollar budget shortfall. More demoralizing, the director informed them of the plan to contract out the entire adult mental health system, including Project Enable. The EMA is not sensitive to such events; if it were, the results certainly would have reflected it in this case.

On the other hand, the EMA was useful in identifying issues relevant to morale. For example, EMA question four showed that as a group, workers felt that their ability exceeded that needed to do their job. It asks: "How about your ability to do your job? A.-I have a lot more ability than my job calls for; B.-My job doesn't make use of many things I can do well; C.-My job makes use of some things I can do well; D.-My job just about fits me; or, E.-I think I am where I now belong and that my present job will lead to a better one. The group score for this question was 20. The standard score range for this item is 64-70. When this score was presented to the group for comments. Diane said: "Most of the time we were on auto-pilot. But that has changed since we have been involved with the study. I feel energized." Parenthetically, my guess is if an EMA survey had been conducted at meeting six this score would have been much higher. During the middle phase, the team members were really using their individual and collective skills.

Nevertheless, question four is but one of the critical issues related to morale identified by the EMA. Based upon the following comments from the EMA, the survey also identified issues that concerned the staff's perceptions of their relationship with top management, as well as issues concerning pay, work environment, and security: "They don't really know us!" "They have little regard for working conditions and pay." [Management is] distant from the program." "Historically, Neighborhood House Association has been out of touch with us. I hope that will change."

The EMA also picked up the strong cohesion within the group, and the high regard for the director, and Neighborhood House Association. For example, in Part III on the EMA, under “Additional comments about your job,” the comments were: “High stress, low pay.” “Enjoy colleagues—keeps job acceptable.” When this comment was read to the group, Loren commented: “That about sums it up!” (laughter).

The issue of pay came up repeatedly; not only in the EMA survey, but during the meeting that the group was attempting to identify a process to improve. The following excerpt was taken from that discussion: “The county pays about \$10 thousand more than we get paid for doing the same job. There is nobody looking out for us, and we serve the most difficult patients in the system. I would like for someone in Neighborhood House Association to go to the county and say we have good workers and we need to pay them.”

The Continuous Quality Improvement Training.

This CQI process was atypical from the perspective of CQI training. Usually, the top executives receive an overview, and middle management and employee receive extensive training in CQI. In this case, the team and the director received one two-hour training. Subsequent training was supposed to be provided on a just-in-time basis. Based on the pre and post training discussions, and evaluations, and researcher observations, the CQI training successfully familiarized the participants with the fundamental CQI concepts and tools. The CQI training received an overall rating of 3.8 out of a possible 4.0 on the evaluations.

In conclusion, the team could have used significantly more training and support, because they did not subsequently spend significant time attempting to apply the CQI concepts or the tools in the implementation process. Neither did the team spend a significant amount of time discussing the problems identified for improvement in the training exercise session. The team and the director did not receive additional CQI training after the initial training. This means that the just-in-time strategy did not work in this case. In fact, during the individual interviews, one of the participants admitted, in retrospect, that the team could have used more training and advice, but they never obtained it.

Identifying a CQI process to Improve

Again, the team did not substantially consider or use the data generated from the Employee Morale Assessment survey. The team considered the three problems identified in the training, however, none was selected. Nevertheless, in the beginning, the workers were energized by the CQI implementation. CQI can be implemented to improve the morale of workers. Diane stated: "Most of the time we were on auto-pilot. But, that has changed since we have been involved with the study—I feel energized."

Moreover, the workers in this case appeared motivated more by intrinsic rather than hierarchy and extrinsic rewards. Once the implementation was underway, the relationship that developed among the members of the team was non-hierarchical. An example of their lack of hierarchy and democratic process was that someone other than the program coordinator or a senior clinician was selected as the team facilitator. The facilitator was selected for various reasons

other than occupying a position of authority; because she did not. One person felt that the program coordinator should have been selected as the facilitator. The others felt that she was a valuable member of the team and a good organizer.

Pay, in terms of adequacy of the pay, and equity influence worker satisfaction. However, the nature of a person's job may have a greater influence on morale, than pay because in order to feel important, people need to be challenged to achieve. Brainstorming, the team considered a pay increase. They decided that a pay increase was not feasible, and it would not result in a significant increase in morale or improve the quality of patient care. One of the members put it quite eloquently: "If we get a raise, that would only be a temporary fix. But, we would still be looking at the same problems that affect morale in the first place."

The CQI process stalled in the proposal writing phase. The workers contributed the loss of momentum to the fact that they got busy in the program, and the facilitator took time off to get married. It was obvious that the group had grown dependent upon the facilitator to get things done. My observation is that the team did not have the training or the administrative support needed for the proposal writing phase of CQI. However, the team finally developed and presented a CQI proposal to the director (Appendix M). The proposal requested funds to create a library and cooking classes. This was when the team realized that it would have been better if they had involved the director.

In conclusion, the lack of training and collaboration with management lead to the team's loss of momentum and ultimate demoralization. Workers cannot

implement CQI alone. This team appeared to succumb because it lacked appropriate training, consultation, administrative support, and management buy-in.

This does not diminish the findings that the implementation of CQI can improve morale and the quality of patient care. Energized by the process, the team spent its time gathering data and discussing ways to improve the therapeutic program for the Day Rehabilitation patients.

The Experience of Implementing CQI.

Based on the findings of research question two, the primary resource that the CQI implementation requires is time. The workers also need a substantial amount of support and training. In addition, the findings indicate a need for an assessment of the participants learning styles in order to meet the specific learning requirements of the group members. This might help members better learn and apply the CQI. Some of the responses reflect members' frustration with applying the CQI quality tools. The facilitator in particular was not able to apply the seven quality tools taught in the training to the CQI process (Appendix K). Because of her frustration, she tended to discount the entire CQI training. Additional training is required to understand and use the quality tools. The quality tools, when understood and used correctly, are effective for analyzing and solving organizational problems.

Before I get into what motivated the workers to follow through or not follow through with specific processes, apparently, no matter what managers do, the aura of intimidation is a factor in the workers' minds. Whether this perception is a result of the workers' fear or a result of the organizations' dominant

culture (Morgan 1986) is a subject for another study. One informant replied to the question of why he continued to participate in the CQI process: "I didn't know I had an option." On the other hand, most of the participants enjoyed the learning process and the prospect for positive change: "For me it was pretty interesting." "We were in a cocoon. It gave us the opportunity to get involved and look around at different places. Besides, I like doing something new." "It was a change of pace. When you do the same thing day in and day out, learning something new is great." "Hopefully, we can develop a library with new materials." "It became interesting to me. As we began to talk about how to improve the program. It became exciting to think about what we can do." "I felt we were already committed. And, because there were some things we really needed to do. I hope we can make some changes." "Because they have to tell us why they say yes or no. That gives me a feeling of empowerment. That just makes more sense than giving a proposal and getting a flat yes or no. Even more, they have to try to get to yes because it is in the best interest of the patients. It's a very unique approach. It's not unusual to have a boss just steam roll over you. It was that way at my last job."

In conclusion, workers tend to know what is politically feasible in their organization. One of the issues of concern for the researcher, was why the team did not spend more time addressing the issues identified by the Employee Morale Assessment. Individual Interview question six is an attempt to understand why the group did not spend more time on the results of the EMA. It asks: Why did you not pursue the issues raised by the Employee Assessment Survey? "Here,

everyone knows what's important. At first we started to look at some of the issues that came out of the survey; employment, and safety issues, but by the third meeting these things like pay scale and safety fell by the wayside. We went on to milieu issues." Researcher: "Why?" "It just goes to show that there is a certain intimidation by management." Researcher: "But management was not there." Ernie: "I still think people are afraid." Cherry: "Because they know that nothing would ever come of it. We had a security guard before and we weren't going to get more money. We see the sickest most combative patients in the system. If we were going to get a raise we would have it already." Loren: "I think we focused on quality of patient care. Maybe we realized that not much was going to change with our salaries. We hit reality. We looked at what we could change. Besides, we are in this profession to help the patients; and if we want more money, we can move on down the road. I have to say, I have never had a better boss than Fay." Diane: "Because of a feeling of it not being safe to pursue those issues. We are horribly under-paid for what we do. We deal with patients that nobody wants to see. No Fortune 500 company would want to deal with a patient who thinks that the CIA is after him all the time. Maybe its not a pay thing; if we had the resources to do what we want to do for the patients, it would be OK." Jane: "Because we decided to pursue the issues that we had the best chance of accomplishing. Given the time limits, it wasn't feasible—plus we would have to get a lot of people involved." Ben: "I think it would have to do with the fact that we could readily impact patient-related issues. We thought maybe if we were successful, we could then try pay issues. Primarily, we have a

better chance of success with a patient issue. So, I thought we may as well do that and go from there. If we pursued the pay issues and failed, would we want to pursue the next issue?"

Finally, It is very difficult to get workers to view the implementation of CQI as part of their job. Ben: "This was a extracurricular activity, not our main job. It was something beyond what we had to do. I turned in my project and periodically asked Cherry about it."

How is Morale Affected by the Implementation of CQI?

Morale was increased by the implementation of CQI. The director sensed the group was initially, ambivalent, but once they got started, "they were pumped-up." Here are a few of the comments by the team members: "For me it was pretty interesting." "We were in a cocoon, It gave us the opportunity to get involved and look around at different places. Besides, I like doing something new." "It was a change of pace. When you do the same thing day in and day out, learning something new is great." "It helped us to dream about what we could do here at Project Enable." "It put some energy in the group that we didn't have before." "I think before we were on auto pilot." "CQI was good because it helped us to focus on what we could improve." "Otherwise, it opened communication and made us investigate some things that we wouldn't have otherwise. It gave us hope." "It became interesting to me. As we began to talk about how to improve the program. It became exciting to think about what we can do. Finally, "because there were some things we really needed to do. I hope we can make some changes."

Disappointment was predictable for the self-directed team in this case. The group expectations were highest by the time they reached the proposal phase, but the team's limited knowledge of CQI, limited skill with the CQI tools, and their lack of administrative support resulting from working in isolation, meant sure frustration. Without the director's support and participation in the process of identifying the process to improve, writing the proposal, steering the process, and clearing the path, the CQI proposal was bound to have difficulty. This was difficult for the workers who had worked so hard.

How Much Time Does the Implementation of CQI Involve?

The team spent approximately one hundred hours in addition to the meeting time to implement CQI.

Recommendations

This study of a CQI implementation illustrated that CQI could successfully be used to assess and improve morale in a community mental health center. The CQI process initially increased morale. In addition, the team opted to improve patient care as opposed to pursuing a pay increase. However, the effort weakened and demoralization ensued. An indication of the depth of the demoralization, was the impression among some of the participants that CQI did not work. Correspondingly, the team viewed the CQI process as extracurricular; not their real job.

The team's frustration and decline resulted because they did not obtain consultation, training, or the administrative support necessary to fully understand

CQI, adequately use the quality tools, or get buy-in from management for the CQI proposal. Ultimately, the team was demoralized because their proposal did not achieve the expected praise or buy-in from the director. It is typical, according to Brown et al. (1994), for the momentum generated during the initial phases of a CQI effort to wane: "Performance on most measures is essentially flat. Morale is down, and most employees perceive TQM to be just another program to deal with in addition to their regular work. Often this perception is reinforced by the organization itself" (p. 73).

In conclusion, the collaboration between the workers and management necessary to create a learning organization did not occur. This case highlights the importance of the need for workers to collaborate with management in every aspect of the CQI process. A fundamental change in the relationship between the employees and management is necessary to getting the worker and management to work together in a non-hierarchical manner. By working together, workers and management can transform their organization into a learning organization using CQI to address the morale of the internal customer. How to bring about the collaboration between management and workers is the question.

There are many answers to the question of how to facilitate collaboration between workers and management. Using Seymour's (1993) loose-tight model of implementing CQI is highly recommended. The loose-tight model, with modification, is an approach in which senior officers can function as members, facilitators, and leaders. The officers demonstrate commitment and engage in detailed

and comprehensive planning with employees, often assembled in teams to execute quality improvement procedures.

What follows is a meeting-by-meeting description of what occurred in this CQI implementation, along with recommendations about what can be done differently to achieve collaboration between the workers and management (Appendix N).

The First Meeting

At the inaugural meeting on June 29, 1996, the director introduced the implementation of CQI, then turned the meeting over to the researcher. The researcher explained the study, obtained informed consent, and administered the Motivation to Participate survey and the Employee Morale Assessment survey. This was confusing to the workers because the researcher had stated that his role was observer. By the researcher taking such an active role in the beginning, he created the perception that he was the CQI facilitator. Although he repeatedly stated that his role was observer, the group looked to the researcher for guidance and he gave none. To avoid confusion in the future, the researcher's activities should be limited to observation.

The manager might start the meeting by presenting the idea that to increase morale and the quality of care, radical change is needed in the way that mental health does business. There are two important ideas to get across in this introduction. First, together, workers and management can transform mental health into a learning organization through dedication to continuous quality improvement (CQI). Second, the way CQI increases morale and the quality of care is through the satisfaction of both the internal customers (workers, managers and others

inside the organization) and the external customers (patients, other programs, and the community). Avoid labeling the initiative TQM, QOL, or CQI. This only allows workers to differentiate the proposal from their real job (Brown et al., 1994). Instead, frame the CQI effort in terms of the transformative cultural changes that CQI behaviors can bring about. Focus on the processes necessary for the creation of a learning organization. Emphasize how satisfying the internal and external customer can increase morale of the organization and the quality of care. Next, the manager can introduce the appointed outside consultant.

The consultant's role is to assist in the change process by facilitating dialogue and advising the group (both workers and management). However, caution is warranted because creation of a quality officer, Brown et al. (1994) wrote, "is often a mistake" (p. 76). Outside consultants often know little about the culture of the organization. Lacking this knowledge, they tend to generate copious CQI activities, but few measurable outcomes. Often consultants make themselves indispensable by promoting themselves. Moreover, the bureaucracy attached to expert-based CQI efforts can cause a decrease in productivity as well as morale problems. The organization should minimize these potential problems by addressing them in the consultant's contract. To avoid the perception that the consultant is indispensable, limit the appointment to a specified period of time.

The consultant's activities at this meeting are limited to giving an overview of the process and explaining the roles of the participants (including the researcher), answering questions, and administering the motivation and morale surveys. The consultant should give the group (managers and workers)

homework at the end of the session. The group is asked to be prepared to discuss how workers and managers can work together to transform their organization into a learning organization that addresses morale and the quality of care. The participant handouts are copies of Senge's article: Transforming the practice of management (1991, November), and Rost's article: Leadership development in the new millennium (1993, November).

The Second Meeting

At the July 14 meeting, the team and the director received a comprehensive CQI training (Appendix J). After an assessment of the participant's learning styles, the consultant, the trainer, or both should, using the homework assignment, first brainstorm with workers and managers about how to work together to transform their organization into a learning organization. The consultant, the trainer, or both (may be one person) may lead the managers and workers in a discussion about how to use collaborative leadership to work together. The main point to get across in this session is that managers and workers can use the collaborative model of leadership to work toward the mutual purpose of transforming their organization. The purpose is to become a learning organization by using CQI to improve morale and the quality of care.

Leadership training is the last of the five module-training program suggested by Brown et al. (1994). However, it is essential to provide the participants with collaborative leadership theory to pattern their behavior after from the outset. Careful selection of the leadership trainer (consultant/trainer) is important. A trainer from a graduate level leadership studies program, such as the program at

the University of San Diego, is required to conduct the training sessions. One of reasons that leadership training fails to prepare people to participate in leadership is due to antiquated theories of leadership (Brown et al., 1994).

The word leadership has been ill-defined and used synonymously with numerous terms, especially the term management. The result wrote Burns (1978) is that we know little about leadership. Deming taught that a definition is indispensable to a theory (Dobyns & Crawford-Mason, 1991). I use the word leadership as Rost (1993) defines it. "Leadership is an influence relationship among leaders and their collaborators who intend real change that reflect their mutual purposes" (p. 99).

There are two important points that the trainer must get across to the participants about collaborative leadership. First, researched extensively, the collaborative paradigm of leadership is different from traditional paradigm of leadership (Appendix O). The collaborative model of leadership uses influence behaviors to bring about transformative change based upon mutual purposes. All of the quality experts agree that in order for CQI to succeed two conditions are required: management buy-in and worker buy-in. The implication of this study is that the management model is a difficult model to use to collaborate with workers, because for management the use of positional power to control subordinates is not only legitimate but also often desirable. Workers tend to avoid management because of their perception of the power that they have over them.

In order for CQI efforts to succeed, management will have to operate from a model in which they have power with the workers. One of the critical differences

between collaborative leadership and management is the distinction between the power to influence versus the power to control others (Miller, 1986). This is an important difference between leadership and management because as Senge (1991) notes, managers often avoid learning (especially with and from subordinates). Generally, the word learning invokes the image of individuals using knowledge as status. Often managers treat their knowledge as status. They hoard knowledge, and often hurl ideas at a given topic in what appears winner takes all contests. These competitive, oppressive interactions tend to proceed from discussion, to concussion, to percussion (Senge, 1990).

Continuous quality improvement is about the participants using their collective intelligence. In learning organizations, team learning is important not individual learning. Therefore, all must commit to radically change their views about learning. The leadership trainer must help convince participants that the relationship among the workers and management must be a collaborative, influence relationship. That is why a graduate level trainer with credentials in collaborative leadership, is required for a successful leadership training. The collaborative model of leadership is compatible with CQI because it promotes continuous learning and mutual interpersonal growth.

The Third Meeting

The third meeting took place on July 28. The researcher gave an overview of the study, discussed the details of the CQI implementation, and presented the findings from the Motivation to Participate survey and the Employee Morale

Assessment survey. Again, it is better to limit the role of the researcher to observation. Alternatively, the consultant should present the findings of the surveys for group discussion. Then, after a short presentation of the findings from the group survey on dominant learning styles, the trainer conducts a session on the CQI philosophy (Brown et al., 1994). The essential components of this training are continuous quality improvement, systems thinking, and using the leadership approach to transform the organization to focus on internal and external customer satisfaction. It is very important to emphasize that the customers must be included in the dialogue and decisions.

The Fourth Meeting

The fourth meeting was held August 11. The researcher explored with the team their reasons for selecting the team facilitator. Instead, the consultant might facilitate a dialogue among workers, with input from management, about the role and expectations, as well as who is best suited for the position of facilitator. The workers will ultimately decide, but it is important for all to have input into the decision. Keep in mind that in Seymour's loose tight model, managers can act as facilitators. Next, the trainer will provide training on leader skills, cause analysis, measuring performance, and process improvement (Brown et al., 1994). The trainer must have case examples of how to apply the training material in community mental health programs

The Fifth Meeting

On August 25, the team facilitator facilitated a discussion with the team about the selection of a CQI process to improve. Alternatively, the trainer should

provide training on the quality tools. The trainer should facilitate a group exercise to help workers and management to select at least three processes to improve. The participants should also practice using the quality tools in this training.

The Sixth Meeting

The September 8 meeting was a continuation of the team dialogue regarding to the selection of a process to improve. Instead, the facilitator should conduct a meeting with the workers and management. First, graph on a Pareto Chart the processes identified in the training session for improvement. Then, the group facilitator can lead a brainstorming exercise to identify additional processes to improve. Place the additional identified processes on a revised Pareto Chart. Now, the group can make a final selection of a process to improve.

The Seventh Meeting

At the September 22 meeting, the team brainstormed about how to improve the therapeutic program. Instead, the facilitator should conduct a brainstorming session. The group can create a Flow Chart that identifies all relevant processes linked to the proposed project. Next, they should identify all other programs and people that are affected by the process. The idea is to help the group to identify those groups and individuals to be included in the decision-making process.

The Eighth Meeting

The November 20 meeting was another brainstorming session on how to create a therapeutic program. The team decided to conduct a patient survey. Instead, the group should decide, based upon the data on the Flow Chart data,

who will be on the guidance team, and the process action team. The consultant can help the group clarify the roles and expectations of these committees.

The Ninth Meeting

The team discussed the patient survey data at the December 8 meeting. Instead, the guidance team and process action team should complete a flow chart of the daily activities taking place in the therapeutic program. Next, they should decide on what data to collect. The consultant will be able to help the participants decide what methodology and quality tools to use for data collection. For example, if the group decides to conduct a survey of the patient's needs, graph their responses on a cause and effect diagram. Illustrate the patient issues on a Pareto Chart. In the same vein, if the group decides to visit other Day Rehabilitation Programs, training on benchmarking is in order. Benchmarking can help determine which programs are worthy of a visit (Brown et al., 1994).

The Tenth Meeting

On January 26, the team discussed the data that they collected from their visits to stores and other Day Rehabilitation programs. They did not use any of the quality tools to present their findings. As already mentioned, patients' issues are effective when graphed on the cause-and-effect diagram and the Pareto Chart. In addition, discussion of the visits to Day Rehabilitation Programs should be in terms of benchmarking objectives.

The Eleventh Meeting

On February 2, the team discussed developing the CQI proposal. Instead, both the guidance team and the process action team should decide on the

specific changes needed to implement the process improvement. The guidance team and the process action team should come to a consensus on the specific changes. A flow chart of the decision-making process will inform participants of the feasibility issues to address. If a proposal is necessary, the guidance team is there to provide for needed support. The consultant can also provide support. Ultimately, mutual support is desirable.

The Twelfth Meeting

On May 9, the team presented the proposal to the director. Kept out of the loop, the director did not have the perspective to support the proposal. The alternative recommendations provided above should increase the potential buy-in from both workers and management. However, the implications of this study go beyond the recommendations given above. The literature suggested that to lower costs and increase the quality of patient care, managed care efforts must create learning organizations that address employee morale. This study examined the implementation of CQI from the perspective of the mental health worker to ascertain the effect on morale. The self-directed team worked in a non-hierarchical fashion to successfully implemented CQI to assess and improve morale, but was unable to sustain it because they did not obtain management participation or buy-in.

The implications of this study for the broader managed care effort is consistent with the advice of CQI experts and learning organization theorists: the effort must have buy-in from both management and workers to succeed. Moreover, this study highlights the fact that managers and workers need a model in which

they can collaborate on organizational change using influence behaviors. Using data based and consensus decision-making, the collective intelligence of everyone in the organization can focus on the problem of lowering costs, increasing morale, and increasing the quality of care. The problem of getting workers and managers to collaborate for mutual purposes is underscored by this study. If managed care efforts are to succeed workers and managers must learn how to learn, work, and play as a team.

The Need for Further Study

There is a need for qualitative studies of community mental health workers and management implementing CQI using the collaborative model of leadership (Rost, 1993). The study should focus on the perspectives of management and the workers to see if morale can be improved and sustained over a substantial period. There is a lack of descriptive data about how manager and workers use influence behaviors such as persuasion to transform organizations. Such studies would not only provide valuable knowledge currently lacking, but increase our knowledge about how to implement CQI to create learning organizations.

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APPENDICES

The Fourteen Points & The Seven Deadly Diseases

- 1. Create constancy of purpose for improvement of product and service.**

Dr. Deming suggests a radical new definition of a company's role:

Rather than to make money, it is to stay in business and provide jobs through innovation, research, constant improvement and maintenance.

- 2. Adopt the new philosophy. Americans are too tolerant of poor workmanship and sullen service. We need a new religion in which mistakes and negativism are unacceptable.**

- 3. Cease dependence on mass inspection. American firms typically inspect a product as it comes off the assembly line or at major stages along the way; defective products are either thrown out or reworked. Both practices are unnecessarily expensive. In effect, a company is paying workers to make defects and then to correct them. Quality comes not from inspection but from improvement of the process. With instruction, workers can be enlisted in this improvement.**

- 4. End the practice of awarding business on the price tag alone. Purchasing departments ordinarily operate on orders to seek the lowest-priced vendor. Frequently, this leads to supplies of low quality. Instead, buyers should seek the best quality in a long-term relationship with a single supplier for any one item.**

5. **Improve constantly and forever the system of production and service.**
Improvement is not a one-time effort. Management is obligated to continually look for ways to reduce waste and improve quality.
6. **Institute training.** Too often, workers have learned their job from another worker who was never trained properly. They are forced to follow unintelligible instructions. They can't do their jobs well because no one tells them how to do so.
7. **Institute leadership.** The job of a supervisor is not to tell people what to do nor to punish them but to lead. Leading consists of helping people do a better job and of learning by objective methods who is in need of individual help.
8. **Drive out fear.** Many employees are afraid to ask questions or to take a position, even when they do not understand what their job is or what is right or wrong. They will continue to do things the wrong way, or not do them at all. The economic losses from fear are appalling. To assure better quality and productivity, it is necessary that people feel secure.
9. **Break down barriers between staff areas.** Often a company's departments or units are competing with each other or have goals that conflict. They do not work as a team so they can solve or foresee problems. Worse, one department's goals may cause trouble for another.
10. **Eliminate slogans, exhortations and targets for the work force.** These never helped anybody do a good job. Let workers formulate their own slogans.

11. **Eliminate numerical quotas.** Quotas take into account only numbers, not quality or methods. They are usually a guarantee of inefficiency and high cost. A person, to hold a job, meets a quota at any cost, without regard to damage to his company.
12. **Remove barriers to pride of workmanship.** People are eager to do a good job and distressed when they cannot. Too often, misguided supervisors, faulty equipment and defective materials stand in the way of good performance. These barriers must be removed.
13. **Institute a vigorous program of education and retraining.** Both management and the work force will have to be educated in the new methods, including teamwork and statistical techniques.
14. **Take action to accomplish the transformation.** It will require a special top management team with a plan of action to carry out the quality mission. Workers cannot do it on their own, nor can managers. A critical mass of people in the company must understand the Fourteen Points, the Seven Deadly Diseases and the obstacles.

The Seven Deadly Diseases

1. **Lack of constancy of purpose.** A company that is without constancy of purpose has no long-range plans for staying in business. Management is insecure, and so are employees.
2. **Emphasis on short-term profits.** Looking to increase the quarterly dividend undermines quality and productivity.

3. **Evaluation by performance, merit rating or annual review of performance.** The effects of these are devastating—teamwork is destroyed, rivalry is nurtured. Performance ratings build fear and leave people bitter, despondent, beaten. They also encourage defection in the ranks of management.
4. **Mobility of management.** Job-hopping managers never understand the companies they work for and are never there long enough to follow through on long-term changes that are necessary for quality and productivity.
5. **Running a company on visible figures alone.** The most important figures are unknown and unknowable—the “multiplier” effect of a happy customer, for example.
6. **Excessive medical costs for employee health care, which increase the final costs of goods and services.**
7. **Excessive costs of warranty, fueled by lawyers who work on the basis of contingency fees.**

Consent to Act as a Research Subject and Consent to Record Research Subject Form

I understand that Gary D. Zomalt is a University of San Diego doctoral student conducting a research study, and a San Diego County Mental Health Services employee. I have been selected to participate in this study, and I understand that I will be observed, and asked questions about my perceptions and participation in various continuous quality improvement activities. I give my consent to be recorded with both audio video equipment during CQI meetings..

My participation in the study is entirely voluntary. I understand I may refuse to participate at any time without jeopardy. I understand that the data collection could take hours of my time. Except for possible minor fatigue or slight anxiety, participation in the study should not involve any added risks or discomfort. Other than slight anxiety, the recording should not cause discomfort. My participation in recording is entirely voluntary. I understand I may refuse recording at any time without jeopardy.

I understand my research records will be kept appropriately confidential. My identity will not be disclosed without consent required by law. I further understand that to preserve my anonymity only the personal data that I allow will be used in any publication of the results of this study.

Gary D. Zomalt has explained this study to me and answered my questions. If I have other questions or research-related problems, I can reach him by pager at 973-5703.

There are no other agreements, written or verbal, related to this study beyond that expressed on this consent form. I have received a copy of this consent document.

I, the undersigned, understand the above explanations and, on that basis, I give consent to my voluntary participation in this research.

Signature of Subject

Date

Location

Signature of Researcher

Date

Motivation to Participate questionnaire

1. **What motivates your participation in this study?**

2. **What are your expectations?**

- 3 **What problems do you anticipate?**

4. **What concerns or questions do you have about the study?**

5. **What kind of training do you think you will need beyond that which was
discussed?**

Employee Morale Assessment questionnaire

In an attempt to make Project Enable a better place to work, we would like you to take this attitude survey.

This questionnaire gives you an opportunity to state clearly how you feel about your job. You can be perfectly frank about your responses, for you are not to sign your name, nor will this questionnaire ever be shown to your employers or to anyone representing them. It is an honest endeavor to find out what employees really think, so that management policies and employee relationships can be strengthened.

When you have filled out this questionnaire, give it to Gary D. Zomalt. The questionnaires will be analyzed and tabulated. A report will be made to you and your director summarizing employees' viewpoints, but the questionnaires themselves will not be shown to management. This study is important for your future work happiness. Be honest and be fair in your replies.

This questionnaire is divided into three parts. Part I asks for general information: your age, hourly earnings, length of service, and department. Part II asks you to indicate your reaction to a number of present practices and policies. Note that you merely mark your answer with an X. No other writing is necessary. However, space is provided in Part III on the final page for you to write any additional remarks, if you so desire.

Don't forget, be frank and be fair. Now start with No. 1 below and complete the questions in order please. Take your time, and don't confer with any fellow employees as to how you should answer any question. Give your own honest opinions.

1. In age I am:
 - A. 24 or under
 - B. Between 25 and 29
 - C. Between 30 and 39
 - D. 40 or over

2. My hourly earnings are from:
 - A. \$ 5 per hr. - \$7 per hr.
 - B. \$ 7 per hr. - \$9 per hr.
 - C. \$10 per hr. - \$15 per hr.
 - D. \$15 per hr. - \$20 per hr.

3. I have worked for the company approximately:

- A. Under 1 year
- B. 1 to 4 years
- C. 5 to 9 years
- D. 10 years or over

4. During the last month I have worked entirely or mainly in the following department (mark one only)

- A.
- B.
- C.
- D.
- E.
- F.
- G.
- H.
- I.
- J.
- K.

Part II. To indicate your answer to each question, merely place an X in the space before the statement that most nearly expresses your opinion.

YOUR JOB.

1. How do you like your present job?

- A. I don't like it.
- B. I'd prefer something else.
- C. I just accept it, neither liking it nor disliking it.
- D. All things considered, I like it pretty well.
- E. I like it fine.

2. Is the atmosphere of your workplace:

- A. Extremely hot, cold, drafty, or dusty
- B. Usually unpleasant
- C. Occasionally unpleasant
- D. Generally satisfactory
- E. Excellent most of the time

3. Is the lighting at your workplace:
 - A. Very bad.
 - B. Poor
 - C. Just barely good enough
 - D. All right
 - E. Just right for the work to be done

4. How about your ability to do your job?
 - A. I have a lot more ability than my job calls for.
 - B. My job doesn't make use of many things I can do well.
 - C. My job makes use of some things I can do well.
 - D. My job just about fits me.
 - E. I think I am where I now belong and that my present job will lead to a better one.
5. For the most part, fellow employees in my department are:
 - A. Unfriendly.
 - B. Indifferent to me.
 - C. All right.
 - D. Cooperative.
 - E. Very friendly.

6. Compared to other pay rates in your office or plant, do you consider your rate:
 - A. Extremely low.
 - B. On the low side.
 - C. About right.
 - D. Above average.
 - E. Quite generous.

7. How about the chances of your getting hurt on the job?
 - A. There are lots of chances of getting hurt; some could be eliminated.
 - B. There are still plenty of chances of getting hurt, although the company has eliminated some of them.
 - C. There is some chance of getting hurt, but it is not bad.
 - D. Most chances of getting hurt have been eliminated.
 - E. There is not much chance for getting hurt.

THE BOSS.

The next 7 questions refer to your manager or immediate supervisor.

8. In attitude toward you personally, is your boss:

- A. Always unfair.
- B. Often unfair.
- C. Sometimes fair, sometimes unfair.
- D. Usually fair.
- E. Fair at all times.

9. If you have a complaint, how does your boss usually receive it?

- A. Does nothing about it.
- B. Usually tries to talk me out of it.
- C. Passes it on to a higher boss, but generally nothing happens.
- D. Listens carefully and acts on those that seem just.
- E. Accepts all complaints in good spirit and investigates, then gives a clear decision.

10. How well does your manager or supervisor keep you informed on company policy, plans, and developments?

- A. Not at all.
- B. Seems not too well informed.
- C. Informs me some of the time.
- D. Most of the time.
- E. All of the time.

11. How well does your supervisor plan the work of your group:

- A. There is no planning.
- B. Occasional planning but not good.
- C. Tries to plan most of it.
- D. Work is regularly planned.
- E. Careful, systematic planning at all times.

12. How well does the supervisor explain new things to employees?

- A. Never bothers.
- B. Explanations are not clear.
- C. Sometimes explains quite well.
- D. Most of the time gives clear instructions.
- E. Explains carefully and patiently.

13. How does your supervisor discipline employees who deserve it.?

- A. Bawls them out in front of other employees.
- B. Uses sarcasm in front of other employees.
- C. Is quite direct, but takes employees aside.
- D. Criticizes in private and explains why.
- E. Criticisms are always helpful and never given in the presence of others.

14. I believe that my boss:

- A. Is not qualified for the job.
- B. Lacks some necessary qualifications.
- C. Is fairly well qualified.
- D. Is quite well qualified.
- E. Is highly qualified.

YOUR COMPANY

15. Compared with other employers in your community, how well does this company treat its employees?

- A. Most others are better.
- B. A few others are better.
- C. About as well as average.
- D. Our company is better than most.
- E. Ours is decidedly the best.

16. Do you feel that the company:

- A. Has little genuine regard for employees.
- B. Looks upon them as workers rather than as human beings.
- C. Gets by satisfactorily in handling employees.
- D. Really understands employee problems.
- E. Shows high regard for the employees' welfare.

17. In its relationships with the community, I believe our company:

- A. Has built ill will.
- B. Does not have the respect of the citizens.
- C. Should do more than it has.
- D. Has built some good will.
- E. Has built a lot of good will.

18. When you tell your friends what company you work for, how do you feel?

- A. Ashamed to admit it.
- B. Not happy about it.
- C. Neutral about it.
- D. Glad I don't work for certain other companies.
- E. Proud to tell it.

19. In its relations between employees and management, I think the company is:

- A. Doing a poor job.
- B. Has considerable room for improvement.
- C. About average.
- D. Pretty good.
- E. Decidedly outstanding.

20. Which one of the following in your opinion shows greatest consideration to employees:

- A. Your immediate supervisor.
- B. Manager of the department.
- C. Top management of the company.

21. Which one of the following in your opinion shows the least consideration to employees:

- A. Your immediate supervisor.
- B. Manager of the department.
- C. Top management of the company.

22. The care and maintenance given to washrooms and toilets is:

- A. Poor
- B. Fair
- C. Good

23. The cleanliness of the lunch room is:
- A. Poor
 - B. Fair
 - C. Good
24. The food and vending machines are:
- A. Poor
 - B. Okay
 - C. Quite satisfactory
25. Prices in the cafeteria are:
- A. Entirely too high
 - B. Okay
 - C. Quite reasonable
26. What percentages of profit on sales after paying taxes do you think your company makes?
- A. 1 percent
 - B. 5 percent
 - C. 10 percent
 - D. 15 percent
 - E. 20 percent or more
27. What is your opinion of your company's method of inducting and training new employees?
- A. Not enough attention is given to new employees
 - B. I have no opinion on this matter
 - C. They are being well treated and properly trained.
28. How much do you think the company has to pay for hospitalization insurance for each employee annually?
- A. \$50.00 - \$100.00
 - B. \$105.00 - \$150.00
 - C. \$155.00 - \$200.00
 - D. \$205.00 - \$250.00
 - E. \$255.00 or more

29. Do you feel that prompt action is taken on safety recommendations?

- A. No
- B. Sometimes
- C. Yes

30. Do you frequently receive orders from more than one person?

- A. No
- B. Yes

31. If you answered yes above, do orders sometimes conflict?

- A. No
- B. Yes

32. How do you feel about working overtime:

- A. Do not like it at all
- B. Do not mind it occasionally
- C. Neutral about it
- D. Like it all the time

PART III.

If you wish to offer any suggestions or criticisms not covered by your answers in Parts I and II, you may use the space below. Your comments will be typed and included in the report made to your company showing the results of these questionnaires—but these forms will never be seen by any supervisor or executive of your company. So, if you wish, write anything you want to. You are not required to write anything here unless you want to. ***Do not sign your name.***

Additional comments about your JOB:

Additional comments about your immediate SUPERVISOR:

Additional comments about your COMPANY:

Any other comments:

When you have completed your questionnaire, fold it once and drop into the locked box. Thanks for your cooperation.

Results

Motivation to Participate Questionnaire

1. What motivates your participation in this survey?

- **Change may occur.**
- **Would like to help the researcher get degree.**
- **Sounds like a good study.**
- **I respect people working on a Ph.D.**
- **I will be given time off work to participate in study.**
- **I am interested in sharing information and ideas.**

What are your expectations?

- **Management will listen and respond.**
- **Good study.**
- **Poor follow through by management.**

3. What problems do you anticipate?

- **The truth may cause hurt instead of helping.**
- **Group unable to keep things confidential.**
- **Getting honest answers.**

Poor follow through by management.

4. What concerns do you have about the study?

- **Information may not be appropriately used.**

5. What kind of training do you think you will need beyond that which was discussed?

- **Unknown.**

Results
Employee Morale Assessment

Part II. To indicate your answer to each question, merely place an X in the space before the statement that most nearly expresses your opinion.

YOUR JOB.

1. How do you like your present job?

- A. I don't like it.
- B. I'd prefer something else.
- C. I just accept it, neither liking it nor disliking it.
- D. All things considered, I like it pretty well.
- E. I like it fine.

70 (70-82)

2. Is the atmosphere of your workplace:

- A. Extremely hot, cold, drafty, or dusty
- B. Usually unpleasant
- C. Occasionally unpleasant
- D. Generally satisfactory
- E. Excellent most of the time

60 (56-71)

3. Is the lighting at your workplace:

- A. Very bad.
- B. Poor
- C. Just barely good enough
- D. All right
- E. Just right for the work to be done

60 (63-70)

4. How about your ability to do your job?

- A. I have a lot more ability than my job calls for.
- B. My job doesn't make use of many things I can do well.
- C. My job makes use of some things I can do well.
- D. My job just about fits me.
- E. I think I am where I now belong and that my present job will lead to a better one.

20 (64-70)

5. For the most part, fellow employees in my department are:

- A. Unfriendly.
- B. Indifferent to me.
- C. All right.
- D. Cooperative.
- E. Very friendly.

90 (88-77)

6. Compared to other pay rates in your office or plant, do you consider your rate:

- A. Extremely low.
- B. On the low side.
- C. About right.
- D. Above average.
- E. Quite generous.

53 (47-52)

7. How about the chances of your getting hurt on the job?

- A. There are lots of chances of getting hurt; some could be eliminated.
- B. There are still plenty of chances of getting hurt, although the company has eliminated some of them.
- C. There is some chance of getting hurt, but it is not bad.
- D. Most chances of getting hurt have been eliminated.
- E. There is not much chance for getting hurt on my job.

53 (62-68)

THE BOSS.

The next 7 questions refer to your manager or immediate supervisor.

8. In attitude toward you personally, is your boss:

- A. Always unfair.
- B. Often unfair.
- C. Sometimes fair, sometimes unfair.
- D. Usually fair.
- E. Fair at all times.

76 (74-77)

9. If you have a complaint, how does your boss usually receive it?

- A. Does nothing about it.
- B. Usually tries to talk me out of it.
- C. Passes it on to a higher boss, but generally nothing happens.
- D. Listens carefully and acts on those that seem just.
- E. Accepts all complaints in good spirit and investigates, then gives a clear decision.

100 (68-70) Fair, but no praise for individuals or group.

10. How well does your manager or supervisor keep you informed on company policy, plans, and developments?

- A. Not at all.
- B. Seems not too well informed.
- C. Informs me some of the time.
- D. Most of the time.
- E. All of the time.

60 (72-75)

11. How well does your supervisor plan the work of your group:

- A. There is no planning.
- B. Occasional planning but not good.
- C. Tries to plan most of it.
- D. Work is regularly planned.
- E. Careful, systematic planning at all times.

60 (62-68)

12. How well does the supervisor explain new things to employees?

- A. Never bothers.
- B. Explanations are not clear.
- C. Sometimes explains quite well.
- D. Most of the time gives clear instructions.
- E. Explains carefully and patiently.

80 (71-76)

13. How does your supervisor discipline employees who deserve it?

- A. Bawls them out in front of other employees.
- B. Uses sarcasm in front of other employees.
- C. Is quite direct, but takes employees aside.
- D. Criticizes in private and explains why.
- E. Criticisms are always helpful and never given in the presence of others.

46 (69-74)

14. I believe that my boss:

- A. Is not qualified for the job.
- B. Lacks some necessary qualifications.
- C. Is fairly well qualified.
- D. Is quite well qualified.
- E. Is highly qualified.

86 (72-79) Highly qualified, but needs to work on "B" above.

****Average range for this section when totaled (70-74)***

YOUR COMPANY

15. Compared with other employers in your community, how well does this company treat its employees?

- A. Most others are better.
- B. A few others are better.
- C. About as well as average.
- D. Our company is better than most.
- E. Ours is decidedly the best.

53 (62-66)

16. Do you feel that the company:

- A. Has little genuine regard for employees.
- B. Looks upon them as workers rather than as human beings.
- C. Gets by satisfactorily in handling employees.
- D. Really understands employee problems.
- E. Shows high regard for the employees' welfare.

50 (62-68)

17. In its relationships with the community, I believe our company:

- A. Has built ill will.
- B. Does not have the respect of the citizens.
- C. Should do more than it has.
- D. Has built some good will.
- E. Has built a lot of good will.

70 (62-68)

18. When you tell your friends what company you work for, how do you feel?

- A. Ashamed to admit it.
- B. Not happy about it.
- C. Neutral about it.
- D. Glad I don't work for certain other companies.
- E. Proud to tell it.

70 (63-69)

19. In its relations between employees and management, I think the company is:

- A. Doing a poor job.
- B. Has considerable room for improvement.
- C. About average.
- D. Pretty good.
- E. Decidedly outstanding.

46 (60-64) *Average range for this section totaled (64-67)

20. Which one of the following in your opinion shows greatest consideration to employees:

- XA** Your immediate supervisor.
- .
- B. Manager of the department.
- C. Top management of the company.

21. Which one of the following in your opinion shows the least consideration to employees:

- A. Your immediate supervisor.
- B. Manager of the department.
- XC** Top management of the company.
- .

22. The care and maintenance given to washrooms and toilets is:

- 3A.** Poor
- 3B.** Fair
- C. Good

23. The cleanliness of the lunch room is:

- A. Poor
- 3B.** Fair
- 2C.** Good

24. The food and vending machines are:

- 1A.** Poor
- 4B.** Okay
- C. Quite satisfactory

25. **NA** Prices in the cafeteria are:

- A. Entirely too high
- B. Okay
- C. Quite reasonable

26. **NA** What percentages of profit on sales after paying taxes do you think your company makes?

- A. 1 percent
- B. 5 percent
- C. 10 percent
- D. 15 percent
- E. 20 percent or more

27. **NA** What is your opinion of your company's method of inducting and training new employees?

- A. Not enough attention is given to new employees
- B. I have no opinion on this matter
- C. They are being well treated and properly trained.

28. How much do you think the company has to pay for hospitalization insurance for each employee annually?

- A. \$50.00 - \$100.00
- B. \$105.00 - \$150.00
- C. \$155.00 - \$200.00
- 1D. \$205.00 - \$250.00
- 1E. \$255.00 or more

29. Do you feel that prompt action is taken on safety recommendations?

- 2A. No
- 4B. Sometimes
- C. Yes

30. Do you frequently receive orders from more than one person?

- 4A. No
- 2B. Yes

31. If you answered yes above, do orders sometimes conflict?

- A. No
- 2B. Yes

32. How do you feel about working overtime:

- 2A. Do not like it at all
- 1B. Do not mind it occasionally
- C. Neutral about it
- D. Like it all the time

PART III.

If you wish to offer any suggestions or criticisms not covered by your answers in Parts I and II, you may use the space below. Your comments will be typed and included in the report made to your company showing the results of these questionnaires—but these forms will never be seen by any supervisor or executive of your company. So, if you wish, write anything you want to. You are not required to write anything here unless you want to. ***Do not sign your name.***

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San Diego Mental Health Services

Training and Development

Training Evaluation

Training: _____ Date: _____

Trainer(s): _____

Indicate which personnel division describes your **primary** responsibilities:

- ☐ Clerical (Administrative Secretary, Intermediate Clerk Typist, etc.)
☐ Clinical (Mental Health Specialist, Social Worker, Psychiatrist, Nurse, etc.)
☐ Management (Chief, Regional Manager, Program Manager/Coordinator, etc.)
☐ Support (Analyst, Special Program Coordinator/Specialist, Admin. Asst., etc.)

EOMO DEMOGRAPHIC DATA: (Mark ONE ethnicity, please)

- ☐ African American ☐ American Indian ☐ Filipino
☐ Hispanic ☐ Asian & Pacific Islander ☐ Other

☐ YES, I am Over 40 years of age.
(If NO, leave blank)

☐ Female

☐ YES, I am Disabled.
(If NO, leave blank)

☐ Male

Please rate this course on a scale of 1 to 4		Poor 1	Fair 2	Good 3	Excellent 4
Relevance to my needs					
Organization (Clear objectives; logical transitions; punctuality; schedule met?)					
Content (Current information; practical application of material; appropriate to your level of knowledge?)					
Innovation (Did you learn anything new?)					
Instructional Methodology (Handouts; visual aids; varied classroom presentation?)					
Delivery (Speaking style and ability; factors of interest?)					
Objectives (Learning objectives were met.)					

As a result of this training, I will: _____

Other comments: _____

The Individual Interview questionnaire.

1. What was your motivation to participate in the study in the beginning?
2. Why have you continued to participate in the in the CQI process?
3. The process appears to have stalled temporarily at one point, why do you think that happened, and, did you take any personal initiative to move the process along; to keep it on track?
4. What did you like or did not like about the CQI training?
5. How compatible were the CQI tools to your needs?
6. Why did you not pursue the issues raised by the Employee Assessment Survey?
7. What were the problems associated with implementing CQI?
8. How much time have you spent doing CQI above and beyond the meetings?
- 9.

EMA Tally Sheet

SAMPLE TALLY SHEET

Project Enable Day Rehabilitation

Number of Questionnaires 40

Item	Tally	%	No	Extension	Index
1.	A <u>3</u>	8	3	6	
	B <u>6</u>	16	6	24	
	C <u>9</u>	24	9	54	
	D <u>13</u>	36	13	104	
	E <u>6</u>	16	6	60	
Totals	100	37	248	67	

x=3

2.	A <u>1</u>	3	1	2	
	B <u>5</u>	13	20	20	
	C <u>6</u>	15	6	36	
	D <u>16</u>	41	16	128	
	E <u>11</u>	28	11	110	
Totals	100	39	296	76	

To calculate scores multiply the figures in the "Number" column according to the following formula:

1. The figure in the Number column opposite the first response (A) is multiplied by 2.

2. The figure in the Number column opposite the second response (B) is multiplied by 4.

3. The figure in the Number column opposite the third response (C) is multiplied by 6

4. The figure in the Number column opposite the fourth response (D) is multiplied by 8.

The figure in the Number column opposite the fifth response (E) is multiplied by 10.

The totals are placed in the extension column. Next, the extension scores are totaled. One can see the total for question 1 is 248; and, the total for question 2 is 296.

Next, the Numbers column is added for each question. The total for question one is 37; for question 2 the total is 39. Then divide the total in the Extension column (248 for question 1) by the total in the Number column (37). The result is 6.7. To convert 6.7 into a morale index, simply multiply it by ten. The result in the example for question 1, which asks: "How do you like your job?," is 67.

EMA Standardized Score Index

Question	Subject of Question	Standard Average Morale Index
1.	Like present job	79
2.	Atmosphere	64
3.	Lighting	64
4.	Use of abilities	68
5.	Fellow employees	80
6.	Pay rates	44
7.	Accident risk	67
Average morale index for questions about jobs		67
8.	Attitude of boss	78
9.	Complaint handling	71
10.	Informs employees	75
11.	Plans work	65
12.	Explains new things	75
13.	Disciplines employees	75
14.	Qualified for the job	73
Average morale index for questions about boss		73
15.	Comparison with other employers	66
16.	Regard for employees	66
17.	Community relations	79
18.	Pride in company	67
19.	Employee management relations	70
Average morale index for questions about company		70
Average morale index for all 19 questions		70

Quality Improvement Tools

Foundations

1) Benefits of high quality:

2) Quality Improvement Process:

Key Principles

1) Defining Quality:

2) Identifying Customers (consumers):

3) Identifying Suppliers (providers):

4) Involving Teams:

5) Data-based decision-making:

Brian Moffitt, 1993

PDCA Process

Plan

Do

Study

Act

Problem Solving Tools

1) Flow Chart - representation of steps in a process

(see handout)

2) Cause and effect (fishbone) diagram

3) Checklist - a list to track observations in order to look for patterns

4) Pareto Chart - bar graph with frequency on vertical axis and service characteristics on horizontal axis

5) Histogram - bar graph with frequency on vertical axis and measurements on the horizontal axis

6) Scatter diagram - graphs relationship of one variable to another

7) Run / Control chart - display of data points as they are gathered over time

The Seven Quality Tools

Flowcharts

Flowcharts are step-by-step, schematic pictures used to plan stages of a project or describe a process being studied. As outlines of a sequence of actions, they provide team members with common reference points and a standard language to use when talking about an existing process or project. They can also be used to describe a desired sequence and order of a new, improved system (Scholtes, 1988, pp. 2-18).

Pareto Charts

A Pareto chart is a series of bars whose heights reflect the frequency or impact of problems. The bars are arranged in descending order of height from left to right. This means the categories represented by the tall bars on the left are relatively more important than those on the right. The name of the chart derives from the Pareto principle ("80% of the trouble comes from 20% of the problems"). Though the percentages will never be that exact, teams usually find that most trouble comes from only a few problems. Pareto charts are useful throughout a project: early on to identify which problem should be studied, later on to narrow down which causes of the problem to address first (Scholtes, 1988pp. 2-25).

Histogram

As we have already seen with the Pareto Chart, it is very helpful to display in bar graph form the frequency with which certain events occur (frequency distribution). The Pareto Chart, however, only deals with characteristics of a product

or service, e.g., type of defect, problem, safety hazards (attribute data). A Histogram takes measurement data, e.g., temperature, dimensions, and displays its distribution. This is critical since we know that all repeated events will produce results that vary over time.

Cause-and-Effect Diagram

The cause-and-effect diagram, also called a “fishbone diagram” because of its appearance, allows you to map out a list of factors thought to affect a problem or desired outcome. This type of diagram was invented by Kaoru Ishikawa, and hence is also called an “Ishikawa diagram.” It is an effective tool for studying processes and situations, and for planning.

A cause-and-effect diagram is essentially a pictorial display of a list. Each diagram has a large arrow pointing to the name of a problem. The branches off the large arrow represent main categories of potential causes or solutions (Scholtes, 1988, pp. 2-26).

Scatter Diagram

A Scatter Diagram is used to study the possible relationship between one variable and another. The Scatter Diagram is used to test for possible cause and effect relationships. It cannot prove that one variable causes the other, but it does make it clear whether a relationship exists and the strength of that relationship.

Control Chart

A control chart is a time plot with one extra feature: it also indicates the range of variation built into the system. The boundaries of this range are marked by

upper and lower statistical control limits, which are calculated according to statistical formulas from data collected on the process. Control charts help you distinguish between variation inherent in a process (variation from a “common cause”) and variation arising from sources that come and go unpredictably (“special causes”). Points that occur outside the control limits are signals of special causes of variation, meaning it should be relatively easy to track down that source and prevent its recurrence. Data points that stay within the control limits indicate that most variation is coming from common causes. If all points stay within the control limits, the only way to make improvements is to fundamentally change some aspect of the process materials, procedures, equipment, training, etc. (Scholtes, 1988, pp. 2-33).

Run Chart

Run Charts are employed to visually represent data. They are used to monitor a process to see whether or not the long range average is changing. Run Charts are the simplest tool to construct and use. Points are plotted on the graph in the order in which they become available. It is common to graph the results of a process such as machine downtime, yield, scrap, typographical errors, or productivity as they vary over time.

DAY REHABILITATION PROGRAM**Patient Survey Results****THE STAFF AT PROJECT ENABLE CAN HELP ME THE MOST BY:**

- Helping me to stay on my medications
- Helping me get along with people
- Listening to us
- Being there for us
- Not yelling at us
- Being concerned about us
- Being patient
- Interacting with us
- Helping us by talking about our illness

IF THE FOLLOWING CHANGES WERE MADE AT PROJECT ENABLE, I THINK IT WOULD BE MORE INTERESTING OR MORE HELPFUL TO ME:

- No confusing classes
- More counseling
- More respectful of me
- Be more friendly

I WISH WE HAD A CLASS IN:

- Scuba Diving
- Horse riding
- Cooking
- Red Cross Class

- Make-up
- History of illness
- People in history who were mentally ill
- Side effects
- How to socialize and how to make friends
- Math

I SOMETIMES DO NOT LIKE TO COME TO PROJECT ENABLE BECAUSE:

- Do too many of the same things
- Don't feel well early in the A.M.
- Too much medication
- Slowed Down (?)
- Sleepy
- Too long

THE DAYS I LIKE THE BEST AT PROJECT ENABLE ARE:

- Bread Days
- Outings
- Drug Education
- Medication Management
- Dancing
- Holiday Celebrations
- Talking with staff

I THINK I WOULD LIKE PROJECT ENABLE MORE AND WOULD ATTEND MORE OFTEN IF:

- We had longer outings
- Talk about our problems
- We had a changed schedule
- We had hands-on activities
- The staff were more friendlier

CQI Proposal**May 13, 1996**

TO: Frances Hill, RN, Director,
Neighborhood House Association,
Project Enable

FROM: Cynthia R. Lewis-Long, Facilitator,
Staff Process Action Team

**RE: REQUEST FOR DAY REHABILITATION LIBRARY WITH A
DISCRETIONARY REVOLVING FUND, KITCHEN, AND COOKING UTENSILS.**

BACKGROUND

The staff process action team has been meeting since July of 1995. The team decided that in order to improve the quality of care to the Day Rehabilitation clients, we must attempt to meet their perceived needs. Less redundant and more relevant educational experiences, and cooking classes were identified as needs by clients in a December 8, 1995 survey, conducted by the team (see Attachment A). We concur with the clients that our curriculum needs to be totally and continually revised, and that the clients do need instruction on cooking. The staff process action team members have researched and found a number of educational materials and videos that would not only hold the clients interest, but be very instructional. We have also visited other Day Rehabilitation programs and learned a great deal about how they meet their clients needs. It was interesting to find that Project Enable's clients seem to be much more impaired by their illness, along with tendency to have an additional diagnosis such as developmental disability and/or substance and alcohol dependency. Lack of appropriate materials to rehabilitate the clients is a common problem among the Day Rehabilitation programs.

FUNDS REQUESTED AND PROPOSED DISTRIBUTION

The following items are needed to implement the revised rehabilitative educational component of the Day Rehabilitation program.

Library Fund

A \$100 revolving library fund limited to \$500 annually, which is accessible on short notice through the Project Enable director's office is needed to take advantage of the sales on specialized educational materials.

The San Diego County Mental Health Services' library is a good resource, as well as the other municipal libraries, but Project Enable clients require any number of special education materials that can only be obtained from specialty stores. Much of this material is published for duplication and can be shared.

Bookshelves

\$119.98 plus tax is needed to purchase two bookshelves in which to keep the educational materials. Bookshelves are needed to organize and preserve the books of material. Also, the intent is to catalog the material so that it can be loaned to other programs who wish to borrow them.

Kitchen

\$408.50 is needed to purchase a microwave oven, electric skillet, hot plates, mixing bowls and utensils. A cooking class is vital to the nutritional and independent functioning of the clients.

Itemization

\$100.00 Revolving fund limited to \$500 annually.

\$119.98 Bookshelves

\$408.50 Kitchen

Microwave	\$189.00	Circuit City
Electric Skillet	\$ 29.99	Montgomery Wards
Hot Plates	\$ 59.99	Sears
Mixing Bowls	\$ 24.99	Mervyns
Utensils		JC Penneys
Mixing Spoons	\$ 3.49	
Spatula	\$ 3.99	
Measuring Cups	\$ 3.99	
Measuring Spoons	\$ 4.99	
Pots & Pans	\$ 69.99	
Pot Holders	\$ 1.59	
Dish Towels	\$ 2.49	
Aprons	\$ 14.99	

\$628.48 Total

\$ 40.36 Tax

\$668.84 Grand Total

Table of Events

Session	Date	Topic	What Happened	Improvements Indicated
1	June 29, 1995	The implementation of CQI	The researcher was introduced to the staff. The researcher explained the study. Consent was signed. MTP and EMA administered by researcher.	Manager introduces idea of creating a learning organization through CQI to increase morale and quality of care. Introduces consultant who gives MTP & EMA surveys. Gives homework assignment.
2	July 14 th	The CQI Training	Staff and director were given CQI training. Three problems were identified for improvement. Initiation of the CQI process	Consultant & trainer go over homework with group. Leadership training given.
3	July 28 th	Results of the MTP & EMA Survey	Researcher gave a talk about the role & expectations of participants. Presented the findings of the survey	Consultant presents and discusses MTP & EMA findings. Training given on CQI philosophy & leadership approach to CQI implementation.
4	Aug. 11 th	Staff process action team chose a facilitator	Researcher explored with the group their reasons for selecting the facilitator	Consultant facilitates a dialogue between workers & manager to select a facilitator.

5	Aug. 25 th	Identify a process to improve	Discussed pay increase versus other options.	Training on quality tools (including an exercise to identify problems and apply the tools.)
6	Sept. 8 th	Identify a process to improve	Team decided to create a therapeutic program	Workers and management place problems identified by EMA and training on a Pareto Chart. Consultant leads a brainstorming session to identify additional problems. Up-date Chart.
7	Sept 22nd	Discussed changing classes	General brainstorming session	Consultant leads a brainstorming session, after a problem is selected. A flow chart is created to identify who else should be involved.
8	Nov. 20 th	Discussed changing program	General brainstorming	Group selects a guidance and a process action team. Clarifies roles and expectations.
9	Dec. 8 th	Discussed changing program	Patient survey data discussed	Guidance and process action team decides what data to collect and tools to use.
10	Jan. 26, 1996.	Discussed changing program	Results of visit to stores and other programs	Training on benchmarking given and objectives established.
11	Feb. 2 nd	developing a CQI proposal	Finalized decisions, divided up work.	Presentation of findings from data collection.

12	May 9 th	Presenting the CQI proposal	Team presented proposal to the director.	Guidance team and process action teams develop a proposal.
13	December	Review of dissertation chapters. Exit interview	Discussed the proposed changes to chapter four and comments on the study.	Process action team implement proposal.

Leadership: Two Contrasting Paradigms

Traditional	Emerging
Good management	Process distinct from management, good or bad
Leader behavior/traits	Leaders and their collaborators inter- act in a relationship
Do the leader's wishes	Do what both the leaders and collabo- rators wish
Pursue any organizational goals	Pursue purposes that intend real changes
Use any legitimate behaviors	Use influence behavior only
Practiced continuously	Practiced episodically

- These six points of comparison show how dramatically different the emerging paradigm of leadership is from the traditional paradigm of the industrial era.

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As we approach the 21st century, leadership is shaping up to be:

- A process entirely distinct from management;
- A relationship in which other people besides managers can be leaders;
- A relationship in which the focus is on the interactions of both leaders and their collaborators instead of focusing on only the behaviors and/or traits of the leader;
- A relationship that aims at mutual purposes rather than just the goals of the leader;
- A process in which people intend significant changes as opposed to a process in which they achieve any goal; and
- A relationship in which only influence behaviors are acceptable rather than one wherein all legitimate behaviors (authority and other forms of coercion) are acceptable.
- An episodic affair rather than something people do all the time.

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Distinguishing Leadership and Management

LEADERSHIP	MANAGEMENT
Influence relationship	Authority relationship
Leaders and collaborators	Managers and subordinates
Intend real changes	Produce and sell goods and/or services
Mutual purposes	Organizational purpose
Position not required	Position required
Episodic	Continuous

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Consent to Publish Research Findings

I understand that Gary D. Zomalt is a University of San Diego doctoral student conducting a research study, and a San Diego County Mental Health Services employee. I have participated in the dissertation study: Morale: Implementing Continuous Quality Improvement in a Community Mental Health Center. I understand that I was observed, and asked questions about my perceptions and participation in various continuous quality improvement activities. I gave my consent to be recorded with both audio video equipment during CQI meetings.

My participation in the study was voluntary. I have read the dissertation, and I understand that my anonymity can not be guaranteed in the publication of this study. I further understand that although pseudonyms are used, the study may reveal my identity. I also understand that my consent is required for Gary D. Zomalt to reveal my identity. **I permit Gary Zomalt to publish this dissertation, fully understanding that my identity may be revealed.**

Gary D. Zomalt has explained the above to me and answered my questions. If I have other questions or research-related problems, I can reach him by pager at 529-1320.

I, the undersigned, understand the above explanations and, on that basis, I give consent to my voluntary participation in publication of this research.

Signature of Subject

Date

Location: Neighborhood House Association, Project Enable, San Diego, CA.

Signature of Researcher_____

Date_____