ANALYSES OF INTERORGANIZATIONAL RELATIONSHIPS
AMONG COMMUNITY MENTAL HEALTH ORGANIZATIONS
IN KITIMAT AND TERRACE, BRITISH COLUMBIA (1975)

by

THOMAS WILLIAM COLLIER

B.A., University of Alberta, 1971

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SCIENCE

in

THE FACULTY OF GRADUATE STUDIES
(_department of Health Care and Epidemiology)

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA
September 1979

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Department of Health Care and Epidemiology

The University of British Columbia
2075 Wesbrook Place
Vancouver, Canada
V6T 1W5

Date October 1, 1979
This study is, in part, a product of the efforts of the Kitimat-Stikine Regional District Health Care Research Project (1975). During the course of this project interviews with representatives of local health care organizations were held in order to inventory the kinds and numbers of health care services in the Kitimat-Stikine Regional District.

In assessing the roles of health care organizations in Kitimat and Terrace, British Columbia it became apparent that a number of community mental health organizations in these two centres were experiencing varying degrees of success and/or frustrations in attempting to meet their organizational goals. In attempting to analyse these experiences it became evident that they were frequently described in terms of the activities and decisions of other organizations. It was also considered that individual organizations had unique characteristics of an internal nature which were also seen to affect the relative success they had in meeting their goals.

The question then arose as to the possibility of analysing community mental health services in Kitimat and Terrace in terms of the interrelationships of the organizations which were pro-
viding these services. This was seen to be a reasonable approach to the problem of analysis in that the specific intent of the research project from which this study emanated was to provide an inventory of local health care services.

In considering the methodology for the analysis of these interorganizational relationships a review of the literature showed that there had been three basic approaches to organizational research used to analyse organizational behaviour. These approaches were, in order of their development, analysis of an organization as a single unit in terms of its internal characteristics; analysis of an organization in terms of its relationships with other organizations and, analysis, as a unit, of a group of organizations which have recurrent interactions with one another. It was determined that each of these forms of analysis could be utilized in the context of the community mental health organizations located in Kitimat and Terrace.

This approach has important implications from a planning point of view in that it affords analyses of benefit to planners and administrators of individual organizations within the context of their own organization's internal framework and within the context of the overall activities of other organizations with which they interact. Furthermore, it provides an advantageous perspective to authorities in central planning organizations as
they attempt to coordinate activities of organizations under their jurisdiction.

Five specific variables were selected to facilitate the analysis of interorganizational relationships at each of the three levels. These variables were: resources; power, organizational autonomy; domain consensus; and interorganizational coordination.

The analyses showed that each of the three levels offer unique opportunities to view the interrelationships between and/or among organizations. It was also illustrated that the third level of analysis was an abstract concept that required further development before it could be clearly differentiated from the other levels. The five variables selected to analyse the interrelationships at each level exhibited varying degrees of relevance to the analysis. The main observation was that, although there was some overlap in their application to specific issues which were discussed, the five variables were able to satisfactorily address any factors which were seen to affect interorganizational relationships at each of the three levels.

Overall, the three level approach to analysis of organizational exchange relationships was suggested to be an appropriate method for central planning agencies to better coordinate the activities of organizations under their jurisdiction.
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DEDICATION

To Margie, my wife, and friend.
To Ben, my son.
To Mom and Dad.
ACKNOWLEDGEMENTS

The completion of this study is due in large part to the efforts and inspiration provided by several people. A large debt of gratitude is owed to Dr. Anne Crichton for both her patience and urgings throughout the duration of the study. Thanks also to Dr. Larry Moore for his initial critique of the nascent study and for reading the final document. Dr. Mort Warner and Dr. Pauline Morris shared the duties of third reader for the thesis and while Dr. Warner read the final document both people were of immense help in the sorting out and organization of the various pieces of the study.

Special thanks go to three of my colleagues in the Alberta Division of Mental Health Services; Mr. Gordon McLeod; Mr. Robert Cameron, and Mr. John Forrester for their encouragement and assistance in the completion of the study.

I am grateful to Mr. John Pousette of the Kitimat-Stikine Regional District for arranging for financial assistance which contributed to the continuation of my studies.

Thanks go to Mrs. Shannon Evasiuk and Miss Claudia Atkins for their valuable typing assistance.

Lastly, the most sincere and certain thanks go to my wife, Margie, whose confidence in me, though tested, was finally rewarded.
CHAPTER I

INTRODUCTION

Purpose

It is the purpose of this study to discuss and analyse factors which influence relationships between and among organizations concerned with various aspects of the treatment and care of mentally ill and disabled persons in the communities of Kitimat and Terrace, British Columbia. This discussion and analysis will be accomplished through the application of systems theory concepts of interorganizational relationships. A subsequent purpose is to discuss the significance of these concepts in explaining problems affecting subject organizations. Particular attention will be given to implications which could directly affect the future plans and activities of these organizations. An attempt will also be made to generalize this discussion to other related fields of social policy and planning.
Background

This study is a consequence of the writer's experience as a research assistant to the Kitimat-Stikine Regional District Health Care Research Project (1975). The Kitimat-Stikine Regional District is located in the northwest of British Columbia. The two major centres are Terrace, with a population of 14,500, and Kitimat, with a population of 12,500. (See Appendix I for map of the area.) During the course of this employment interviews with representatives of health care and social service organizations revealed that within the communities of Kitimat and Terrace there are a variety of organizations involved in the provision of different types of community mental health care. Each of the seventeen community mental health organizations incorporated into the study's data base are described in summary form in Appendix II. A number of agencies, associations, and individuals in these two centres described related problems and circumstances which were seen to complicate and/or frustrate their attempts to provide care for the mentally ill and disabled.

Because the community oriented mental health care concept has only recently been operationalized in the study area as an alternative and/or supplement to previously existing services, the advent of this community based treatment philosophy has had an impact on the numbers and kinds of mental health services.
available at the community level. For example, the Community Mental Health Centre in Terrace, under the Provincial Department of Health and Human Resources, was instrumental in the establishment of a short-term residential treatment facility in Terrace. This facility in turn was a catalyst in the creation of a sheltered workshop.

In the restricted geographical setting of Kitimat and Terrace the dynamics of the evolution and operation of mental health care services becomes extremely intricate and interwoven. There are a great many factors that influence efforts to develop a coordinated and integrated community based system for provision of community mental health services. Within the study area there was an expressed concern regarding the perceived lack of support from the Provincial government to help the community organizations to cope with the problems of providing services. Whilst some organizations were satisfied with the support, there were other agencies and groups which were highly critical of either the lack or kind of support they were being offered. Provision of community mental health services under the aegis of the Provincial government has been somewhat fragmented. The reasons for this fragmentation stem from a number of factors such as practical problems in implementing ideal combinations of community based services on behalf of the Provincial departments of Health, Human Resources, and Education; the activity of extra-governmental
groups such as the British Columbia Association for the Mentally Retarded; the relationships between organizations at the community level; and the internal characteristics of individual organizations. While it is apparent that these dynamics may be widely acknowledged and understood within the study area, there still remain major obstacles to the realization of an efficient and effective system for provision of services. Acquisition and disbursement of resources, and the definition and control of organizational jurisdictions are seen to be the primary areas of concern in this regard.

Rationale

Mental health services, as provided in the Province of British Columbia, have been described as "...the most inefficient, ineffective, out-dated, and discriminatory of all our existing social and medical programmes" and as "a maze of conflicting and indefinable forces" (Foulkes, 1973, p.IV-C-12-6). In light of this comment the view of mental health services as an ordered, coordinated, and integrated system does not command much credibility. However, this fact does not preclude the use of the term system in a discussion of the provision of mental health care services. The assumption that the word 'system' imparts an ordered process to any activity is not always true. A substan-
tial body of literature advanced under the banner of general systems theory supports the notion of a rather neutral concept of system. A system has been defined elsewhere in this research as "a set of units or elements that are actively interrelated and that operate in some sense as a bounded unit" (Baker and O'Brien, 1971, p.395). There are, as a consequence of this definition, aspects of both independence and interdependence that are germane to the system concept.

The independent aspect is evidenced by the fact that each unit is distinguishable from its environment. There exists some discontinuity that affords the unit an identity of its own. A boundary exists between the unit and its environment.

The interdependent aspect is evidenced in the recognition of each unit as an open-system. An open-system is viewed as open in the sense that there is an input-output exchange with other units in the environment. This exchange, of course, takes place across the boundaries that define the units. The nature of the input-output transactions between units will vary according to the permeability of these boundaries.

An argument could perhaps be made for viewing the aggregate of the organizational units, or systems as a suprasystem under which all the activities of all mental health care organizations can be incorporated. However, there is an inherent danger in the assumption that there is one coherent system of mental health
care organizations whose "boundaries can be well defined both conceptually and empirically" (Baker and O'Brien, p.132). A suprasystem concept assumes the participation of all organizational units as a unified whole, while in fact there are units which maintain greater or lesser degrees of independence. That is, there are variations in the permeability of the boundaries of the units.

According to the definition above it could be rationally asserted that a unit might take on proportions at either end of an infinite scale. In other words, whatever point of departure is defined as a system there are subsystems and suprasystems which are bounded and which are related in some fashion to the original system. Conceptually, at least, there is a wheel within a wheel image that can be presented from the previous description. The issue that arises as a consequence of this description is the problem in defining at which level a system becomes critical for the purposes of effective analysis.

For purposes of this study the critical level (or boundary) is to be mental health care organizations located in the communities of Kitimat and Terrace, British Columbia. This is to be the point of departure and each organization within this classification is to be regarded as a unit or system. The utilization of specific dimensions to analyze relationships between and among these organizations at three different levels is seen to be one
way of ordering existing services to the mentally ill and dis-abled. Such an ordering process is necessary so as to provide a basis for local planning and change.

Methodology

The research method consisted of interviews during which representatives of health care organizations were invited to de-scribe and discuss the operations of their organizations. The interviews were structured in an attempt to permit a free flowing dialogue and to minimize any feelings of anxiety concerning the purpose of the interview and/or the presence of the research team in the Kitimat-Stikine Regional District. To this end the inter­viewer presented himself as a member of a consultant and research team associated with the Department of Health Care and Epidem­iology at the University of British Columbia. The intent here was to reduce the possibility of introducing local political biases regarding the role of the Regional District in health care planning.

Although no research tool was designed for data gathering, the interview questions were formulated according to a four tier view of organizational behaviour as posited by Dubin (1958, p.61). The four levels; technical, formal, non-formal, and in­formal, were used in order to gain both objective and subjective
information. In each interview the questioning began by solic­
itig technical data such as function of the organization, its
cliente, catchment area, programming, and professional re­
lationships. The questioning then moved to discussion of the
formal structure of the organization and a description of the
hierarchy, staff/line relationships, funding mechanisms, and the
organization's personnel. The non-formal level was discussed in
terms of linkages between organizations (local and non-local) and
individuals within organizations. The intent here was to deter­
mine what really happens in the organizations' hierarchy and what
was viewed to be required in order to get things done. Infor­
mation at the informal level of the organization dealt with
relationships outside the professional sphere of activity.
Social influences and "country club" types of relationships were
included here.

The writer was involved in all interviews regarding mental
health oriented organizations. In some instances two or three
members of the research team participated in the interviews.
Interview summaries were compiled by the writer from notes taken
during the interview. Documents such as letters patent, annual
reports, and advertising brochures were collected as and when
available and were used to supplement the interview reports.
Media coverage of the activities of organizations during the two months of study on location in the Regional District was also incorporated into the research data-base.

Description of Systems Terminology

Writers and researchers involved with systems theory concepts have refined a number of subtle variations in the definitions used in their work. The use of jargon is at times a barrier to the understanding of basic concepts involved. In an attempt to come to terms with the systems theory argot a short narrative is used to describe important terms that are found in this study.

System - is a concept that has been applied to organizational research in recent years. The concept derived from work done by Bertalanffy in the biological sciences during the 1930's. The analogy is drawn from the notion that living organisms, as studied by a biologist, are constantly interacting with their environment. In this analogy organizations are accorded the status of living organisms in that they (the organizations) interact with their own organizational environment. Baker (1970, p.5) uses a definition for a system that would be relevant to both the biologist and organizational theorist. He states that a system is:

"a set of units or elements which are actively inter-related and which operate in some sense as a bounded unit."
Systems Theory - pertains to the study of the concepts involved in the interaction and interdependence of the components of a system as defined above.

Open Systems - "are those through where there is a continuing flow of component materials from the environment, and a continuous output of products of the system's action back to the environment" (Baker, 1970, p.7). An organization viewed as an open system implies that the survival of that organization is dependent upon the nature of the relationships between it and its environment.

Intraorganizational Relationships - are relationships that are evidenced between the units or elements that are components of an organization. Relationships between an administrative board and an executive director or between a supervisor and employees are examples.

Interorganizational Relationships - are relationships that are evidenced between one organization and another. An example of an interorganizational relationship might be an agreement for referral of clients between two social service agencies.

Supraorganizational Relationships - are evidenced between an organization and a higher level system within which the lower level system functions as a subsystem or component (Miller, 1965, p.218). An example here would be the relationship between a local community office of a government agency and the central headquarters in the provincial capital.

Criteria

In stating the purpose of this study three key terms are used. Specifically, these are factors, relationships, and organizations. While these terms may have a certain familiarity
they must be clearly understood in terms of their usage in this thesis.

Factor

A factor, as represented here, is an issue which may influence the relationships between organizations. The factors that are discussed in this thesis are primarily those which were identified through the interview process by various representatives of community mental health care organizations in Kitimat and Terrace. Issues which were not specifically mentioned by the representative are not incorporated into the primary research data and therefore cannot be assumed by the writer to be of concern to the representatives of their organizations. Factors may also be identified through review of other research data such as newspaper articles and reports compiled by organizations in the region. In addition, there may be issues which were perceived by the writer to influence organizational relationships that for one reason or another may not have been identified through the interview processes. Where these types of factors are incorporated into the thesis the rationale for their inclusion shall be developed.

Discussion of factors is not limited by negative or problematic criteria. That is, factors may contribute in a negative
and/or positive manner to organizational relationships. Clearly, discussion and analysis of both types will be included in this thesis.

As defined by Funk and Wagnalls' *New Standard Dictionary of the English Language* a factor is "one of several elements or causes that produces a result". In applying this definition the elements or causes refer to identified issues which lead or contribute to the specific relationships between organizations, that is, the result which is produced.

**Relationships**

While it is possible to preface the term relationship with various adjectives in describing the connection between two or more things, Levine and White (1961) have developed a framework for analysing organizational relationships that identified a common, ever present characteristic. Their argument is that all relationships among local health agencies may be conceptualized as involving exchange. Organizational exchange is defined as "any voluntary activity between two organizations which has consequences, actual or anticipated, for the realization of their respective goals or objectives" (p.585). Organizational relationships are not restricted to those involving mutual exchange. Exchange is viewed as either unilateral, reciprocal, or
joint, which involves a third party recipient.

Exchange thus conceptualized is not limited to the transfer of material goods or immediate gratification. The elements actually exchanged include such things as funding, technology, clientele, and/or information pertaining to these elements.

This broad based approach to the discussion of organizational relationships has received considerable support in organizational research literature. Aiken and Hage (1968) state that most studies of organization interdependence essentially conceive of the organization as an entity that needs inputs and provides outputs, linking together a number of organizations via the mechanisms of exchanges or transactions.

Elling and Hallebsky (1961) use the term "support" in making reference to the availability of certain kinds of resources available to hospitals in upstate New York. For purposes of their research "support" refers to an institution receiving from its environment those elements it needs to achieve its goals (p.190). Organizational relationships, therefore, are seen to be based on exchange processes, as defined by Levine and White, between an organization and its environment which includes other organizations.

Mott (1970) states that "organizations maintain themselves by entering into mutually satisfactory exchange relations with individuals, groups, and organizations" (p.56). An organiza-
tion's continued existence is argued to depend upon other organizations making certain resources available.

Although interorganizational relationships are often discussed in the context of cooperation and mutual satisfaction, relationships of quite the opposite nature can exist. Benson (1975) says that organizations' interactions with one another "may at one extreme include extensive, reciprocal exchanges of resources or intense hostility and conflict at the other" (p.230). The question arises as to whether or not it is appropriate to view conflict and competition as involving exchange. The above definition of exchange by Levine and White does not seem to be compromised in this regard. Support for this claim is found in Aiken and Hage when they state that "the study of interorganizational relationships appears to be one area which can appropriately incorporate the processes of both conflict and cooperation" (p.913). Aiken and Hage rely strongly upon the concept of exchange (especially resource exchange) in their discussion of interorganizational relationships.

It should be noted that physical coercion is not viewed as a constituent of exchange relationships (Levine and White, p. 369).

Organizations

The organizations surveyed and incorporated into this study
are diverse in terms of structure, composition, and orientation to the field of mental health care. In order to discuss and analyse the inter-relationships of these organizations in a meaningful way it is necessary to define what is implied when the term organization is used.

March and Simon (1958) state that "it is easier, and probably more useful, to give examples of formal organizations than to define the term" (p.1). The United States Steel Corporation, the Red Cross, the corner grocery store, and the New York State Highway Department are cited as examples of organizations.

March and Simon excuse their decision to forego the rigours of a definition of organizations because of a major difficulty they see in clearly differentiating between an "organization" and a "non-organization" (p.1).

Etzioni (1964) almost becomes an apologist for the definition by example approach of March and Simon. He says that "corporations, armies, schools, hospitals, churches, and prisons" are organizations while "tribes, classes, ethnic groups, friendship groups, and families" are not (p.3).

Fortunately such ambiguity is remedied through more explicit definitions by a number of theorists researching the organizational field. Furthermore the definitions that are presented are all very closely related and a common thread remains identifiable in these definitions.
Parsons (1956) says that organizations are distinguished from other types of social systems by one definitive characteristic. All organizations have "as a formal analytical point of reference, primacy of orientation to the attainment of a specific goal" (p.64). Further to this "an organization ... produces an identifiable something which can be utilized in some other way by another ... organization" (p.65).

Etzioni (1964) interprets Parsons' definition as meaning a "social unit devoted primarily to attainment of specific goals" (p.3). In a subsequent statement, Etzioni says that "organizations are social units (or human groupings) deliberately constructed and reconstructed to seek specific goals" (p.4).

Katz and Kahn (1966) describe certain characteristics of organizations in terms of the actions of individuals composing the organization. They state that all organizations consist of "patterned activities of a number of individuals" and that "these patterned activities are complementary or interdependent with respect to some common output or outcome; they are repeated, relatively enduring, and bounded in space and time" (p.17).

These definitions and descriptions of organizations are similar enough to show that there is some agreement as to the basic underlying characteristics germane to every organization. For purposes of this thesis these characteristics will pertain.
There must be a group of individuals, working in concert toward a common end or goal.

Beyond the theoretical definitions of an organization there are other specific criteria for the inclusion of an organization in this thesis. Firstly each organization will be geographically located or represented within the boundaries of the Kitimat-Stikine Regional District. Local offices of agencies which have headquarters elsewhere are thereby included in the study.

The second major criterion for inclusion is not as easily defined as a geographic boundary. The difficulty lies in the definition of a mental health care organization. From a realistic point of view one cannot restrict the discussion to organizations ... "labelled mental health. The mental health of the community is in the hands of the schools, the churches, the social agencies, and many other organizations" (CMHA, 1963, p.60). For purposes of this thesis however, there is no attempt to examine the welter of organizations that have various levels of involvement in the mental health care field and to excise appropriate segments from the organization. The logistics of that exercise require that an arbitrary definition be chosen.

In order for an organization to be incorporated into this thesis as a subject, the primary goal of that organization must be directly related to the provision of mental health services. In the case of educational, judicial, and welfare agencies where
mental health services are considered as special supplements to the main programme of the organization only those special services will be discussed. For example, special opportunity classrooms within the school system will be discussed whilst the school system will not, except in terms of the special programme.

Finally, it should be noted that organized consumer groups as well as direct service organizations will be considered in this study.

Format

This study is divided into seven chapters. Chapter I includes the purpose, background, rationale, methodology, format, a discussion of terms pertinent to the thesis, and a discussion of the criteria used in defining factors, relationships, and organizations for purposes of this thesis. Chapter II consists of a broad historical review of the development of community mental health care movement. It is intended that this narrative will provide a longitudinal perspective from which to view the development and current status of the community mental health care services in Kitimat and Terrace. Chapter III consists of two parts. The first is a review of the literature pertaining to systems theory concepts of interorganizational relationships. In this review there will be a short discussion of each of three
levels of interorganizational analysis. These levels deal respectively with internal aspects of organizations which affect interorganizational relationships; relationships between organizations; and relationships among organizations. The second part of the chapter reviews five dimensions relevant to interorganizational relationships. These dimensions are resources; power; organizational autonomy; domain consensus; and interorganizational coordination. Chapters IV, V, and VI will deal respectively with factors affecting the three levels of organization described above. Each chapter will analyse the identified factors at each level in light of the above mentioned dimensions. In Chapter VII after summarizing the major points established in the thesis and discussing the significance of interorganizational theory in explaining various circumstances affecting the subject organizations, implications for community oriented mental health care and other related fields of social policy and planning will be discussed.
CHAPTER II

HISTORICAL ANTECEDENTS TO COMMUNITY MENTAL HEALTH CARE

In this chapter a cursory history of the mental health movement will be presented in two sections. The first will discuss developments prior to World War II and the second will deal with the period from the end of World War II to the present. The intent of the chapter is not to simply chronicle events but to provide examples of and insights into the processes that have led to the present organizational mosaic in the community mental health field.

The community approach to provision of mental health services has been a movement which has generated, over the past quarter of a century, a large amount of attention, concern, and support but has only recently been operationalized as an alternative to previously existing residential services. Inasmuch as these previously existing services have and likely will continue to exist, the advent of the community mental health services is more appropriately described as an addition to, rather than a substitute for, the original services.
It is necessary to have some understanding of pre-existing services in order to gain an appreciation for the extent and nature of the more recent changes. In addition, the development of these new and expanded services must be discussed in order to fully comprehend the issues which presently influence the activities and interrelationships of organizations concerned with delivery of mental health services in community settings.

The historic milestones in the development of the community mental health services in British Columbia paralleled those elsewhere in North America (Foulkes, 1974, p.37). Indeed, the mental health care field, up until the end of World War II, was rather homogeneous, in terms of facility and professional development, both in Canada and the United States. Roberts (1970) says that "The development of mental health services in Canada has not varied appreciably in its qualitative aspects from the rest of North America" (p.21). Allodi and Kedward (1977) reinforce this view by citing the difficulty in describing the "evolution of Canadian psychiatry and its institutions without considering at the same time a number of related events that took place in the United States" (p.219). There are, as shall be discussed later in this chapter, both similarities and differences in the experiences of both countries. The similarities occurred primarily in the years prior to 1960. The early 1960's became the period of differentiation, primarily in the structures that were developed
in the two countries. Because of the similarities this chapter borrows heavily from the abundance of information pertaining to the United States experience. Examples of the Canadian parallels, especially in the early years, do not appear to be as readily retrievable. Nonetheless, they will be used where possible to verify that the United States information is relevant to the Canadian experience.

The Early Years To World War II

Historical recapitulations of the development of mental health services in North America point out that there are identifiable phases defining the evolution of strategies for caring for the mentally ill (Rossi, 1969: Hobbs, 1969: Brand, 1968: Foulkes, 1974). The first phase was characterized by indifference, ignorance, and fear (Foulkes, 1974, p.12) on the part of both the clinical authorities and the general public. The mentally ill were usually viewed with uncertainty and mistrust and were afforded custodial care in prisons, poor houses, attics, or like accommodation.

A change in this approach occurred in the late nineteenth century with the establishment of institutional facilities dedicated solely to the care of the mentally ill. In the United States the activity of Dorothea Dix between the years 1841 and
1887 was the principal factor which influenced the various State legislatures to assume responsibility for more humane custody and treatment of the mentally ill (Yolles, 1969, p.6). This process, which was replicated in Canada (Foulkes, 1974, p.12), removed any responsibilities the public may have had for the care of the mentally ill and fostered in society a comfortable "out of sight - out of mind" attitude. Although the move to institutionalized care was initially based on humanitarian motives (Yolles, p.6; Hobbs, p.29; Schwartz, 1970, p.336) the hospitals of the early 1900's were soon isolated in both a professional and geographical sense. The hospitals stagnated, became overcrowded, and consequently the humanistic motives were compromised through neglect, isolation, and the insular attitudes of hospital professionals which were fostered through these circumstances (Yolles, p.6).

Foulkes has chronicled these developments in the British Columbia experience.

"A statement of principles of the "moral treatment" was written into the 1902 Annual Report. These were listed as essential medicines; good food; regularity of living habits; employment; amusement, and recreation" (p.13).

Foulkes goes on to cite conditions of overcrowding in B.C. institutions which compromised the humanistic approach nearly as soon as it was operationalized.
"... in spite of the transfer of 48 patients to a satellite unit in Vernon in the interior of the province, surplus admissions were accommodated at the New Westminster jail. Some thought was given to accommodating patients in tents during the winter as well as summer when 25 paroled patients were accommodated in this way in 1904" (p.14).

These conditions were to prevail for some years to come. Subsequently the "moral" motivations become more and more obscure with the passage of time. Between 1913 and the end of the Second World War "the basic principles of individualized treatment virtually disappeared" (Foulkes, 1974, p.17).

Treatment Revolutions

It was during this interval that the work of Sigmund Freud came to light and gained widespread prominence and acceptance in explaining the causes of mental illness. Hobbs makes reference to the paradoxical consequences Freudian psychoanalytic thinking had upon the general field of mental health and cites it as a "second revolution" having major impact upon the approach to treatment of mental disorders. While he does not specifically discuss the relationship between this second revolution and the community mental health care field, Hobbs is critical of the tendency for virtually all professionals to become preoccupied with individual, one to one, treatment modalities (p.30). He
believes these approaches were counter productive in terms of providing the most benefit for the greatest number. Psychoanalysis and more specifically "the private practice of psychiatry or psychology ... does not provide a sound base for the development of a national mental health programme" (p.33). Hobbs' argument implies that the legacy of Freud's revolutionary approach to treatment of mental illness may in fact be a double edged sword, on the one hand making advances towards explaining the nature of man's behaviour while on the other hand providing a "tool" far too unwieldy to effectively manipulate in a comprehensive approach to the mental health care field. This notion is supported by Foulkes (1974) when he states that Freud's contemporary Sandor Ferenczi's "prediction that 'the insane asylum will be transformed into a psychotherapeutic institution in which psychoanalytically trained physicians will occupy themselves with each case every day, and if possible, for an hour a day', was far to sanguine" (p.18). The implication of Ferenczi's statement is clearly that the psychiatrist's orientation would become localized within the institution thereby diminishing the role played within the community.

We see, however, that in spite of the advances in psychotherapy the impact of the legislators in dealing with mental health problems was largely limited to maintenance of the over-crowded institutions (Yolles, p.7). Furthermore, "the attitude
toward mental illness remained largely administrative and legal, rather than medical and therapeutic" (C.H.M.A., 1963, p.3).

The Community Orientation

In spite of this regression in the treatment of patients in psychiatric facilities, the period between the early 1900's and the Second World War was one which was crucial to the furthering of the community mental health care system.

The concept of community based psychiatric facilities is cited by Rossi as dating back to the 1890's when medical men such as Frederick Pedersen and John Chapin of the United States proposed the creation of a "psychopathic hospital." This new institution "was to be located in the community it served, in contrast to the location of asylums, and its primary function would be the provision of treatment rather than custodial care" (Rossi, p.11). It was expected then that early treatment, proximity to friends and relatives, and the involvement of the local medical personnel would come to bear heavily on the outcome of institutional care. Such hospitals, in fact, were established in the United States and, while their numbers were not large Rossi asserts that "they were instrumental in stimulating ... community interest in the mentally ill as well as the interest of hospital
personnel in communities." Furthermore the "interdisciplinary approach to the mental health problem ... was the first developed within these hospitals" (Rossi, p.11).

The precursors of present day community mental health clinics were also developed in this era. These early clinics were, in some cases, examples of psychiatric institutions extending the bounds of their facilities into the community. In other instances these clinics were the products of the involvement of research, educational, philanthropic, and eventually governmental organizations in the field of mental health. Rossi suggests that the advent of community clinics in the United States was stimulated substantially in the 1920's by three factors. These were the child welfare movement, the increased public awareness of various mental health problems brought to light by the findings of the prevalence of mental disorders in military personnel during World War I, and the increased activity of the National Committee for Mental Hygiene (Rossi, p.13).

The child welfare movement was largely a product of "concern over juvenile delinquency" and court related punishments (Yolles, p.8). The concept, however, enlarged its scope to incorporate relationships with schools and social agencies. These relationships have persevered over time to a point where the movement has developed such influence that there is considerable evidence that through it a comprehensive range of mental health services for
children can be provided (Yolles, p.9). While there appears to be no unitary body or organization that has furthered this comprehensive view it is apparent also that these early beginnings have yielded long lasting consequences, witness efforts of the Joint Commission on the Mental Health of Children in the United States.

The discovery of mental problems in American recruits during World War I prompted the development in 1930 of a division of mental hygiene in the United States Public Health Services (Yolles, p.8). This eventuation notwithstanding it is apparent that it was not until after World War II had produced grave concerns which were translated into military and economic terms that "the nation's mental health was seen as directly influencing the functioning of the national as well as local governments" (Rossi, p.25). Canada, like many other nations involved in the Second World War, saw health, generally, in a national perspective only after the war showed a need for rebuilding the country.

Voluntary Groups

The advent of citizen involvement in mental health both in Canada and the United States seems to be widely attributed to the effort of Clifford W. Beers in the early 1900's (Yolles, p.7). Beers is credited for founding a small voluntary mental health
organization in the State of Connecticut in 1908. This organization was dedicated to the reform of the gross inadequacies evidenced in the institutional treatment of mental illness which Beers himself had experienced.

From this modest beginning Beers, only one year later and with assistance from men such as Adolf Meyer and William James, established the National Committee for Mental Hygiene. This organization was, at first, primarily oriented toward research which was used to support "public education," lobbying for passage of favourable legislation, and the improvement of the institutional facilities for the care of the mentally ill. Since that time the role of the organization has broadened considerably. In 1950 it became the National Association for Mental Health.

There are other examples of voluntary organizations which have been imported to or created within Canadian borders. Most of these groups were philanthropic in nature or else were based upon the concept of mutual aid. The parent body of the C.M.H.A. is only one of the first. The point here is that citizen participation in the community mental health movement was originated in an era long past. Though the intensity of the citizen involvement has waxed and waned over time it is evident from this present research that its current status and level of importance
is of major relevance to organizational studies in the community mental health field.

Post World War II Years

The slow change of the pattern of organization and financing of mental health services to 1950 "has culminated in what may be a new social concept that may well mark the end of the treatment, in relative isolation, of those afflicted with mental illness and retardation" (Foulkes, p.27).

There has been a turnabout in the rate of change in this pattern so that today there is a rapid acceleration of growth of community mental health concepts. A number of factors have contributed to this phenomenon, some of which have been described in the previous section. There are, however, two catalysts that have been primarily responsible for this rapid change and which have had an impact in both North America and Europe. The first was the advent of psychotropic drugs which demonstrated that mental illness could be controlled, behaviour modified, and subsequently that early discharge from psychiatric institutions was possible. The second factor was an administrative revolution. It was typified by an increased willingness on behalf of the psychiatric institutions to decentralize their facilities by moving from a closed system to a more open approach to treatment.
The hospital became only one of many services such as out-patient, day care, hostels, and community clinics (Foulkes, 1974, p.29; Jones, 1972, p.293). The stays in mental hospitals were shortened and by 1960 there were even decreased in the patient populations of these hospitals (Foulkes, 1974, p.28).

It would be misleading to suggest that these developments were easily brought about. Changes in treatment theories and technologies have generally outpaced their implementation. The art of mental health treatment has not kept in step with the science. As the mentally ill were returned to the community there were many attendant problems. John and Elaine Cumming (1957) conducted studies which showed the reluctance of society to readmit the former psychiatric patients to the community. Social reintegration of institutionalized patients returning to their communities is equally difficult for the patient who may have lost social skills during a hospital stay (Goffman, 1961).

It is apparent that in the 1950's the United States and the Canadian experiences in the community mental health field began to diverge somewhat. The reason for this divergence is related to federal involvement in funding of projects.

In the United States, federal legislators introduced bills that provided financial backing in support of the community mental health concept (Rossi, p.10). In 1955 The Health Amendments Act provided funding to the States in support of mental health
demonstration projects. In 1961 a nation wide project, the Joint Commission on Mental Illness and Health, submitted a report analysing the state of the mental health care field. This document cited the need for change from the institutional approach to care and recommended the establishment of a national mental health programme utilizing community based mental health facilities (Yolles, p.11). In 1963 The Community Mental Health Centres Act was passed which provided substantial funding for construction of community mental health centres. Although in subsequent federal administrations the support granted through this Act was reduced substantially (Gorman, 1976, p.123), it is clear that the federal involvement has had and may well continue to exert considerable positive influence on the community mental health concept in the United States.

In Canada, however, there has been a less vigorous federal involvement. Under The British North America Act of 1867, provinces were given primary responsibility for all health care matters. Within that context, however, mental health, public health, and physical health services have all taken on different structures. Mental health services have remained almost exclusively within the domain of the Provincial jurisdictions. Provincial control over the other services has not been as centralized as it has been for mental health. Public health services in most provinces have moved, over the years since Confed-
eration, from locally autonomous control under the jurisdiction of municipal governments to "the direct provision by the province of local public health services through health units, except in the case of large cities" (Canada, 1966a, p.5). This pattern has led to a shared responsibility for public health services. Hastings and Mosley document that developments in medical and hospital services have also led to a sharing of jurisdictions.

"Until recently, activity by the provinces in the direct provision of hospital service was restricted to maintaining and financing care in mental hospitals and tuberculosis sanatoria. Then during the depression of the 1930's many municipalities found themselves unable to meet the costs of basic assistance, including hospitalization, for their indigent citizens. Provincial assistance to general hospitals and towards plans for financing basic medical care for specific indigent groups began and has steadily grown. This was carried forward by the need for more extensive care for people with certain types of disease, for example, poliomyelitis and cancer. Then provincial hospital insurance programs were developed after World War II in several provinces.

"Under the federal Hospital Insurance and Diagnostic Services Act of 1957 and complementary legislation in each province the operating costs of hospitals are now covered through provincially operated plans. A good deal of supervision and advice on planning and operating hospitals are provided by the divisions concerned with hospitals and the hospital plans either in provincial health departments or in separate provincial hospital commissions. As well, extensive fed-
eral and provincial grants for hospital construction, extension, and renovation are now made" (Canada, 1966a, p.7).

Federal involvement in the form of the National Health Grants Program of 1948 encouraged provincial health surveys which made specific recommendations regarding mental health services (Canada, 1966b, p.5). The recommendations produced by the provinces were, however, not very innovative in that they preferred largely to deal with "expansion and extension of the existing structure and pattern of services" (Canada, 1966b, p.6). This limitation, notwithstanding these surveys, did serve to point out the serious shortcomings of mental health services in terms of manpower and facilities. These Mental Health Grants helped to some extent to inject new vitality into provincial mental programmes (C.M.H.A., p.3) but failed to provide the basis for a coordinated planning effort between the provinces and the federal government.

It is important to make a distinction between the developments in Canada and the United States after 1963. While the United States began to develop its Community Mental Health Centres Canadian psychiatrists through an alliance with the Canadian Mental Health Association agitated for change using as their theme the contention that "mental illness should be dealt with in the same organizational, administrative, and professional
framework as physical illness" (C.M.H.A., p.38). The use of general hospital facilities was advocated as a viable method of providing community mental health services. This was accepted by provincial governments as a reasonable approach to providing comprehensive community mental health care programmes. Clearly the psychiatric wing of the medical profession was anxious for this to happen. They did, in making the recommendations contained in More for the Mind, remain cognizant of the roles of other agencies in the local communities.

The role of the psychiatric centre however was not emphasized. In fact, it was regarded as a poor alternative to facilities in the general hospital. "In some circumstances it may be desirable to base the psychiatric services for a community in a specialized centre, but in the interest of integration with other branches of medicine the psychiatric service in the general hospital should become the standard pattern" (C.M.H.A., p.196).

Hindsight shows that these recommendations were taken seriously by many provincial jurisdictions. Several hospitals, especially those in the large cities have had psychiatric facilities incorporated into their operation. The creation of psychiatric facilities in hospitals led to a future division of authority over provision of services, for in most instances the hospital and not the province retained control over use of the facilities.
Voluntary and professional organizations began to increase their activities on behalf of the mentally ill and disabled. The Canadian Association for Retarded Children was established shortly after World War II (Canada, 1966c, p.13) and the Canadian Mental Health Association began to operate on a higher profile on the federal and provincial scenes as well as at the community level (C.M.H.A., p.5). In later years the Commission on Educational and Learning Disorders in Children (C.E.L.D.I.C.) published its report entitled *One Million Children* in 1969. The C.E.L.D.I.C. report was the product of an amalgam of six Canadian voluntary organizations all very much concerned with specific areas relevant to the mental well being of children.

The voluntary associations and government officials at all levels worked in concert with one another in many respects including research, creation of programmes, and provision of facilities (Canada, 1966c, p.13: Foulkes, 1974, p.32). While these efforts were successful in regard to provision of services and in reshaping public attitudes toward mental illness it also had the unpropitious proclivity to fragment the services. Fragmentation of services was an unavoidable result of the multiplicity of health agencies (government, voluntary, and professional) that prevailed at all levels of society (Goerke, 1964, p.715: C.E.L.D.I.C., Ontario Committee, 1970, p.6).
It should be noted here that there has been a recent advent of consumer oriented, mutual aid organizations. Self help groups have been developed as alternatives to the more traditional professionally staffed organizations. These organizations are not wide spread across the country but in Vancouver, British Columbia an organization called the Mental Patients Association has been in existence for several years and has been developing a very independent role in its approach to mental health services.

The increased availability of psychiatric care as provided by private physicians in the 1950's is another factor which contributes to the division of unified or coordinated mental health services. Coates (1972) has argued further that in Canada planning has been frustrated by professional dominance which is characterized by the psychiatrists desire to provide specialized services to the exclusion of other professionals. These professionals should be able to complement any services beyond those which the psychiatrist is willing or able to provide.

Coates has also been critical of other aspects of the planning process in provision of community mental health services.

"The prime need in mental health services is for a reorientation of planning. Planning should start with a community, examine its needs and problems, identify the smoothly running functions and those which are conflictual, and only after this consider the provision of services and how they best may
be organized. Such a program runs counter to all existing mental health planning in Canada, which has begun by focusing on the most overt and pressing need, namely for psychiatric hospitalization, and in successive order has introduced general hospital use, prepaid psychiatric services and only now and infrequently engages with community services and community planning groups."
(Coates, 1974, p.1).

Although speaking in a United States context the comments of Fairweather, Sanders, Tornatsky, and Harris (1974) are seemingly appropriate to Canada in view of Coates' statements. Fairweather et al state that, historically, change in the field of mental health has never been based on validated premises. "... mental health programmes have more often than not been instituted on the basis of the authority of the advocate for that programme rather than upon any careful longitudinal exploration of the outcomes ...
" (p.2).

British Columbia has not escaped the phenomenon of fragmented services. The pattern of cooperation between governments and voluntary agencies has left a legacy of special schools, classrooms, sheltered workshops, and hostels which are responsible to various jurisdictions. The government has established community mental health centres throughout the province. General hospitals have added psychiatric beds to their acute care programmes and the family physician has begun to widen his approach to the treatment of psychiatric disorders. The public health
units, schools, and voluntary organizations have all become involved in the provision of direct client services (Foulkes, 1974, p.32).

In 1967 the Province of British Columbia acknowledged the need for increased planning for community mental health services. Foulkes (1974) cites the government's statement referring to the reorganization and reorientation of B.C.'s mental health services.

"It will no longer be primarily 'service' oriented but will assume increased responsibility for the overall aspects of mental health planning, in order to facilitate the decentralization and regionalization of mental health programmes throughout the province" (p.34).

This new approach seems to place increased onus upon the local communities for provision of services but at the same time indicates that the province accepts responsibilities in advancing and assisting in this transition to the community.

The consequences of such a policy direction were likely to be significant in determining the nature of specific services provided in British Columbia communities.

The government's desire to involve the grass roots by extending to them both funding and authority may have been premature in some instances. That is, the delegation of responsibilities and power may have had consequences which had not
necessarily been foreseen by the governments (Crichton, 1976, p.64). Further to this Crichton argues that "there has been a general absence of control over local initiatives which has led to uneven development and lack of linkages between different parts of the system" (p.63).

An added consideration here is the demographic and geographic disparities that exist in the Province of British Columbia. With the heavy concentration of population in the lower mainland area there are likely to be disparities in the rates at which the different areas of the Province are going to be able to develop. Policies which are appropriate for areas in the south-west of British Columbia will not necessarily be appropriately applied to sparsely populated areas in the north. Compounding this is the difficult geography of the entire Province which can contribute to problems in communication and transportation.

There will need to be a flexible approach to the administration of the policy which will allow for unique community characteristics. The implications of policy for interorganizational relations within these communities will likely be as significant as the nature of the services provided.

By way of conclusion to this chapter a resumé of an article by Palmiere (1965) is presented which, though written in reference to circumstances in the United States, seems to appropriately apply in summary of the present texture of the community mental
Palmiere cites five specific problems which affect the provision of coordinated health services at the community level.

The first is an inadequate knowledge of the processes and nature of mental illness. This pertains not only to professionals working in the field but to other individuals who for various reasons have interests in the planning for community mental health services. Mental illness is a phenomenon which seems to invite citizen participation and about which many participants have varying levels of understanding.

The second factor is the rapid change in technical, attitudinal, and organizational characteristics. There are an expanding variety of institutions and agencies providing services within local communities. There are as a consequence, problems of competition for resources and coordination of expanded services.

The third and related factor is the overlap which exists between social services and medical care services. Although there are elements of each which pertain to the mental health care field, the interface between the two is subject to friction because of contrasts in the organization and provision of services. The involvement of various types of governmental, voluntary, local, and non-local organizations in each area tends to accen-
tuate the potential for problems in providing local community services.

A fourth consideration relates to the unique characteristics of the community. Every community is different and changing as it grows or regresses. The problems in achieving consensus for programming mental health services are common to both non-local and local organizations. Programmes may have to be implemented according to unique characteristics of the community.

The fifth problem that is an indicator of a turbulent environment relates to the planning process and the lack of a central over-all coordinating body. Cooperation or even coordination become extremely complex propositions to surmount when dealing with multiple jurisdictions. Planning must take into account the multidimensional relationships in the environmental context and as a consequence is seen to be a process requiring considerable patience and understanding on behalf of the actors in the planning exercise.

While the historical developments of the community mental health movement are only briefly summarized here the spirit of the movement can be appreciated through this presentation. The trend toward community mental health is unmistakeable and is evident throughout North America. It has been illustrated here that the trend has evolved in two phases. Prior to World War II the concepts were identifiable but it is the era subsequent which
has witnessed the consolidation and actualization of these con-
cepts in terms of policy and service. While the actual develop-
ment is still in its early stages it is clear that the community
mental health concept has reached the end of its beginning and is
now being tested in the field.
CHAPTER III

INTERORGANIZATIONAL RELATIONSHIPS - LEVELS AND DIMENSIONS

It is the purpose of this chapter to describe the three levels of interorganizational relationships that will be used in describing community mental health care services and to discuss five major dimensions which will be used to develop analysis of relationships at each of the three levels.

The first of the three levels takes the interorganizational perspective. The internal characteristics of an organization are related to the organization's environment. The second level concerns analysis of relationships between organizations that interact with one another on a regular basis. The third and more abstract level conceives of groups of organizations acting as complete social systems within an organizational field.

The second part of this chapter will discuss major variables identified in the literature as being of paramount importance to the nature of interorganizational relationships. These variables will be discussed under the broad categories of resources, power,
organizational autonomy, domain consensus, and coordination of services.

**Interorganizational Relationships - Level I**

Social science research on organizations had been concerned primarily with intraorganizational phenomena such as the individual within an organization, the relations among the members of a group in an organization, informal and formal groups, and structural attributes of an organization (Evan, 1965, p. B217; Elling and Halebisky, p. 188; White, 1968, p. 289; Levine, White, and Paul, 1963, p. 1183).

It is only recently that individual organizations have been studied in relationship to other organizations in a total system (Negandhi, 1970, p. 1). This new approach, notwithstanding, it is important not to ignore the internal aspects of organizations when dealing with concepts of interorganizational relationships. As Zeitz (1975) argues:

"Organizations are not seen as deterministic atoms operating in a generalized field. Rather they are to a greater or lesser extent, instruments of social control and social action ... At the same time, organizations themselves are real social units with their own internal dynamics, with power, and with survival needs which can threaten to subvert the utility of organizational instruments for any rational social ends" (p. 45).
This study is interested in intraorganizational relationships principally as they relate to an organization's relationship with its environment, or more specifically, with other organizations. There is, in this tactic, a subtle turnabout in that the usual approach to discussions of intra and interorganizational relationships deals with the effect of the environment on internal organizational behaviour (Aiken and Hage, 1968). The more traditional approach seems to infer that an organization is a reactive entity when in fact the relationship between an organization and its environment is a double edged sword. That is, just as an organization's internal relationships are affected by the organization's environment so too is that environment influenced by an organization's internal structure and behaviour (Levine and White, 1961, p.590).

Lawrence and Lorsch (1967) have addressed the reactive or adaptive capacities of organizations. They refer to the fit or balance that is established between an organization's internal characteristics and the requirements of an external environment. This "fit" is necessary if the organization is to meet its goals effectively. The inference here is that if an organization does not have internal characteristics consistent with the demands of its environment then the effectiveness of the organization suffers.
Taking a similar posture, Kochan (1975) has said that as organizations pursue their separate interests they must be able to adapt to constraints imposed by other organizations and to "develop an organizational structure which is capable of coping with the others" (p.435).

The reciprocal effect of an organization upon its environment as that organization exerts itself in order to attain its goals is acknowledged by Van de Ven, Emmet, and Koenig (1975, p.20).

Aiken and Hage also deal with the interaction between interorganizational relationships and internal organizational behaviour and structure. They have found that an organization's internal structure has an effect on the kinds of interorganizational relationships in which it becomes involved. Conversely, there are examples in their research that illustrate the effect or consequences that interorganizational relationships have upon intraorganizational structure and behaviour.

Warren, Burgunder, Newton, and Rose (1975) have hypothesized that in some instances there may be certain intraorganizational characteristics that will have an effect on interorganizational relations (p.172). The fact that there were strict limitations placed upon the number of variables examined in this research detracts from the generalizability of the conclusions. Many factors may affect the ability of an organization to realize its
goals as it interacts with its environment (Elling and Halebisky, p.187). An organization may be expected to apply whatever forces it can muster as it seeks to relate with its environment in a manner consistent with its internal and formal goals (Kochan, p.435). In doing so it is expected that internal adaptation as well as environmental adaptation may occur. The degree of impact of these changes upon either the internal aspects of an organization or the organization's environment will vary according to the manner in which these forces are brought to bear. As the organization strives to reconcile its own goals with its environment it is entirely possible that the power of that organization may be such that it is able to impose its will upon the environment. If not that, at least there may be some compromise position to which both the organization and its environment will move.

Zeitz (1975) takes this point of view. He is critical of the tendency to assume that an organization is an already constituted, independently functioning unit. He argues that this assumption is not consistent with the view of an environment which sets constraints upon organizational autonomy (p.40). Both assumptions may apply.

Indeed, as Sheldon, Baker, and McLaughlin (1970) state, flexibility is consistent with concepts of general systems theory (p.346). The open-system view of organizational input,
processes, and output, by definition, requires that a two-way relationship exist between an organization and its environment. While the input from the environment will influence the organization's activities the output from the organization is seen to influence the activities of its environment. "A system (organization) must interact with and somehow adjust to its environment" and "as living systems adapt to their environment ... they also in turn affect their environments and change them" (Baker, 1970, p.8).

**Interorganizational Relationships - Level II**

The second level of interorganizational analysis is concerned with relationships which exist between organizations. In order to differentiate this type of relationship from others described in the organizational research literature it is necessary to keep in mind that it is the organization itself, seen within a group of other organizations, which is the basic unit of observation and analysis (Litwak and Hylton, 1962: Evan, Zeitz). Evan has devised the term organization-set which he defines as the network of organizations which constitute the environment of a single organization. The environment is viewed simply as those organizations with which a specific organization interacts (p. B219). He uses the organization-set to describe relations
between a focal organization and the organizational members of its environment.

Level II analysis may also consist of analysis of relationships on a more limited basis, such as relations between only two organizations (Hall and Clark, 1973).

Van de Ven, Emmett, and Koenig in reviewing the literature have found two approaches to Level II analysis. The first is the comparative approach which focuses on specific organizations and, using specific dimensions, compares them according to the characteristics of their interactions. The second is the relations approach which examines the linking mechanisms between organizations and the circumstances involved in the types of relations that develop.

Whatever perspective is taken, Level II analysis is based on the belief that all organizations function within "an environment of other organizations, as well as a complex of norms, values, and collectivities of the society at large" (Evan, p.218). This concept is axiomatic in contemporary organizational research. The significance of the concept for studies in interorganizational relationships is great. Much of the current research deals with the organization-environment interaction (Mindlin and Aldrich, 1975, p.382). Interdependencies between an organization and its environment "essentially conceive of the organization as an entity that needs inputs and provides outputs, linking to-
gether a number of organizations via the mechanisms of exchanges
or transactions" (Aiken and Hage, p.913).

Interorganizational Relationships - Level III

Organizational autonomy is limited in many respects by
various types of social, political, and economic pressures
(Zeitz, 1967, p.40). In addition, there may be factors which are
quite remote in both a geographical and organizational sense
which can influence or affect any organization's operations.
Organizations at all levels, local, non-local, governmental, and
voluntary can act together, consciously or unconsciously, in
influencing a specific organization's behaviour. "There does not
appear to be a distinct field of interaction at the community
level which is clearly distinguishable from the total process of
multilevel, mixed level interaction" (Warren, 1967a, p.262). The
implication is, therefore, that while an organization may seek to
control its own destiny, to some extent there exists an undeter-
mined number of external factors that will influence every
organization.

Warren (1967b) suggests that it may be more fruitful to view
relationships among organizational units as occurring within an
interorganizational field. In developing the concept the term
"field" has been borrowed from Kurt Lewin who defines it as "a
totality of co-existing facts which are conceived of as mutually interdependent" (Warren, 1967a, p.397). The notion of an interorganizational field "is based on the observation that the interaction between two organizations is affected, in part at least, by the nature of the organizational pattern or network within which they find themselves" (Warren, 1967b, p.397). This approach implies that groups of organizations could be analysed as though they were one large organization (Hall and Clark, p.45: Benson, p.230).

Benson, Kunce, Thompson, and Allen (1973) also subscribe to the concept of the interorganizational field. They state that "when a number of organizations engage in recurrent, extensive interactions with each other, they may be said to form a network" (p.3). This network, like the interorganizational field, becomes the basic unit of analysis. It "has characteristics which are objects of investigation in their own right" (Benson, p.230).

The problem of differentiation between Level II and Level III analyses is central to the understanding of both concepts. The key point to be kept in mind is that while both Level II and Level III acknowledge the existence of networks within which organizations may function it is Level III which purports to view these networks in a larger context.

Neghandhi describes the Level III or interorganizational field approach by saying that relationships among different
organizations are conceived of as occurring in the light of interactions of all members of the interorganizational field (p.4). Emphasis is upon the view of the member organizations participating in a collective unit and there is a subsequent shift "from examining interorganizational relationships between organizations to among organizations" (p.10). Concern thus becomes centered upon "the properties of an aggregate of interacting organizations as distinguished from the properties of the individual organizations themselves" (Warren, et al, p.168).

**Boundary Definitions**

It would seem, however, that the field as described by Warren and the network described by Benson do exhibit similar problems of boundary definition as those of analysis at Level II.

Baker and O'Brien (1971) allude to this when they observe that there are obvious reasons for inclusion of organizations within a specific field. Broadly stated, each of the member organizations may be involved in the field directly or indirectly (p.133). The field, therefore, is, and must be, discrete in some fashion although the clues remain obscure as to how this is accomplished. As Hall and Clark argue "the inclusion of specific organizations and each of their major contacts would result in ever increasing circles of organizations which would not stop
until all organizations are included" (p.54). When put in this light the notion of an interorganizational field or social system of organizations becomes blurred with the Level II approach. At Level II Hall and Clark, as well as Turk (1973b) describe the difficulty involved in determining the boundaries of the organization-set. In reality there is no one organization-set. It is contended that for purposes of research it necessarily becomes a selective process to determine any one "organization-set, network, or system of organizations" (Hall and Clark, p.54: Turk, 1973b, p.57). At Level III the same can be said. "Networks vary in scope and in degree of interactions and must be arbitrarily defined or bounded for research purposes" (Benson, et al, p.4). The boundaries may be defined according to specific variables affecting relationships between two organizations at specific levels of interaction (White), among many organizations at various levels of interaction (Turk, 1973b), or among many organizations at specific levels of interaction (Kochan).

Miller (1971) confirms the researcher's prerogative of arbitrary delimitation. He says that the system or unit of investigation, once identified, will, of necessity, have subsystems and suprasystems. "Every discussion should begin with an identification of the level of reference ... Systems at the indicated level are called systems. Those at the level above are called suprasystems ... Below the level of reference are subsystems ..."
(p.288). The implication is that the "level of reference" may be arbitrarily defined. The identification of subsystems and supra-systems thus become dependent upon the designated level of reference.

**Dimensions Of Interorganizational Relationships**

Interorganizational relationships at all three levels previously outlined are subject to influence from a wide range of factors and variables. It is not intended nor even possible to deal with all potential factors in this study. However, it is relevant to discuss in some depth those variables that receive greatest attention in the literature. While it is not suggested that all of the specific points discussed in this section will necessarily pertain to the issues evidenced in the research data it is intended that this review will provide a basis for an understanding of the nature of interactions that were brought to light in Kitimat and Terrace.

**Resources**

The dimension of resources is perhaps the single, most widely discussed variable affecting the field of interorganizational relationships and one which permeates virtually all its
perspectives. Resources are defined in an economic sense as those elements which an organization requires in order to attain its goals (Levine, White, and Paul, p.1185: Parsons, p.69).

Yuchtman and Seashore (1967) define resources in broader terms as the "generalized means, or facilities, that are potentially controllable by social organizations and that are potentially usable - however indirectly - in relationships between the organization and its environment" (p.892).

There are several lists of resources which authors have devised as essential to the development and preservation of exchange relationships between and among organizations.

Aldrich (1975) describes four types of resources: personnel; information; products and services; and operating funds (p.52). Levine, White, and Paul (1963) state that health organizations require three main resources: clients (recipients of services); personnel; and non-human resources such as equipment, specialized knowledge, or funds (p.1185). Yuchtman and Seashore say that there are four universally required resources. They are: personnel; physical facilities for the organization's activities; a technology for these activities; and some relatively liquid resource, such as money, which can be used to exchange to acquire other resources (p.895).

Parsons (1956) says that all organizations must have land; labour; capital, and an organization to administer these re-
sources (p.69). It would seen that Parsons and Yuchtman and Seashore are in agreement in their approach to essential resources. All organizations must have access to these four essential resources if they are to realize their organizational goals. Other non-economic resources which may be organization specific, that is not required by all organizations, may be acquired through the manipulation of the basic resources (Levine, White, and Paul, p.1185). In addition, resources need not be viewed as tangible items as are money, personnel, and facilities. Abstrated resources also exist in forms such as influence, knowledge, and authority (Benson, p.229: Goerke, p.714: Kochan, p.449: Levine and White, p.369: Baker and Schulber, 1968, p.18). These elements can be ascribed status as resources by virtue of the above definition by Yachtman and Seashore. This is justified in the sense that while these elements do not have physical or economic substance in and of themselves their characteristics do and must, in all cases, issue from such substantive forms (Yuchtman and Seashore, p.893).

In the health care field "few, if any, agencies possess access to all the resources they need to enable them to attain (their) objectives fully" (Levine and White, p.367). This pronouncement is widely conceded. The consequences of this scarcity have been interpreted in a number of contexts pertinent to inter-organizational relationships. Because of the ubiquitous nature
of the resource concepts it is not possible to exhaust all their aspects in one section of this review. It is necessary to deal with them in the context of other dimensions as well. The contexts discussed in this review are power in interorganizational relationships, organizational autonomy, domain consensus, and interorganizational coordination or services. The nature of these dimensions is such that they are quite interrelated as will be evidenced in the following discussions.

Power in Interorganizational Relationships

Social power is defined by Elling (1968) as "the ability to influence the orientation and behaviour of others" (p.119). Supporting that definition is Klein's (1965) comment that it may also be viewed as the extent to which one individual or group may "block or facilitate the gratification of the needs of others" (p.304). Dubin has identified three kinds of power. The first concerns technical skills, expertise, and the relative level of exclusive availability and necessity of those technical aspects (p.30). The second is legitimated authority (p.32) and the third is status (p.36). French and Raven (1960) identify power relationships which are based on the ability of one party to reward or punish another, the legitimated prerogatives of a dominant party, referent power, and expertise (p.612). Using the broad
definition of resources which has been presented previously it may rationally be asserted that organizational power can be seen in a resources context as proceeding from control of elements organizations require to meet their goals and objectives (Klein, 1968, p.51: Cartwright and Zander, 1965, p.5). Elling argues that consent of others must be given before power can be gained and that this consent is dependent upon control of sources of power or resources (p.119).

Klein (1968) states, in this same vein, that power is dependent to a degree upon the perceptions of those involved. "Power exists so long as it is invested in some person, thing, or group by those who are influenced by that power" (p.52). Elling and Klein (1968) agree with Lewis' (1970) assessment that power is more than mere control of economic resources and official authority. It is in large part a function of the quality of the boundary spanning organizational representatives.

Lewis argues that power may stem as well from the quality of the people representing organizations and the quantity of people thus represented. Reasoning ability, interpretation skills, technical knowledge, personal prestige, and charisma of organizational leaders are cited as important determinants of power (Elling, p.123). A slight digression to the role of organizational representatives is in order at this point.
Relationships between organizations are frequently viewed in terms of the organizational representatives who effect and affect the relationship (Lewis, p.74). These representatives are frequently the media through which exchange relations are formulated. "Interaction is rarely the case of the total membership of one group interacting with the total membership of the other group" (Turk and Lefcowitz, p.337). At the community level this view could be extended to account for the fact that virtually all linkages between groups are accomplished by group representatives. Nadel (1957) argues that indeed it is the representatives of organizations who "give meaning to the conception of interrelations between groups" (P.95). It is important to note, however, that there need not be one single group representative. All members of organizations may be viewed as representatives of their organization in the daily routine of carrying out the interactions between themselves and non-members (Turk and Lefcowitz, p.337).

This argument notwithstanding there are specialized representatives who act on behalf of the entire organization as if they were the personification of that organization. These representatives serve to aid in differentiating between organizations in that they present a unitary image of their own organization and thus facilitate formation of stable intergroup relations without merging into a single group (Turk and Lefcowitz, p.341).
At times, however, there may appear to be a blurring of boundaries in that the representatives of organizations can be viewed as a group unto themselves. This may be seen to be dysfunctional for individual groups whose members perceive a misplaced loyalty in the actions of their representatives (Miller and Rice, 1967, p.230). Nonetheless, there are situations where representatives of different organizations form groups for coordinative purposes. The risk of transferring allegiances may exist but it does not seem to preclude such coordinative undertakings. Perhaps the interpretation of misplaced loyalty lies in the perceptions of organizations' members as they assess their leader's ability to assert power in advancing the interests of his organization. The power, or lack of same, in the individual representative's activities involving interorganizational relationships may be the key determinant here.

At the other extreme, these representatives serving on coordinating groups may be unable to rise above the vested interests of their organizations, the consequence being the failure of coordinated action.

One final aspect of power relationships between organizations that should be reinforced is its ever changing nature. As discussed in the following section resource dependence is one factor that has consequences for organizational relationships. The health care field is one which is constantly changing in
terms of technology, manpower requirements, size, and composition in terms of the organizational framework (Klein, p.51: Elling, p.127). Values and attitudes are also important and changing factors which contribute to the turbulent nature of the health care field (Emery and Trist, 1965, p.30: Palmiere, p.568).

Power is neither limited nor absolute because it exists in so many forms (Klein, p.51).

Organizational Autonomy

Organizational autonomy is defined as an "organization's freedom to make relatively major decisions without the consent of other organizations" (Greenley and Kirk, 1976, p.320). Organizational autonomy is seen as a function of the relative availability of scarce resources. The extent to which an organization is dependent upon another depends in part at least upon the extent to which needed resources are controlled by that organization. The nature of interorganizational relationships is in large part determined by the scarcity of resources (Levine, White, and Paul, p.1185: Benson, p.229). Mindlin and Aldrich also state that dependence between organizations is influenced by the degree of competition for and sharing of scarce resources (p.382). In other words, organization A is dependent upon organization B to the extent that B controls resources required by A.
Further to this Clark (1965) argues that limitations in availability of one resource can be mitigated if another, more available resource can be utilized as a lever or incentive to cooperation by organizations with mutual interests and the necessary complementary resources (p.235). Evan concurs with these notions. He suggests that autonomy of an organization may be increased if sources of resources are numerous and decreased if these sources are limited (p.223).

The fact that organizational autonomy is a function of the scarcity of resources leads directly to another important aspect of the resource dimension. In the framework of economics and limited resources there exists the concept of opportunity-cost. Simply stated this concept means that in order to obtain a given product or service something must be given up or sacrificed in exchange. In even simpler terms it means that if an organization exchanges commodity A for commodity B it gives up its claim on A and cannot, ever, use it in exchange again. The point here is that limited resources force choices to be made between alternatives even if all alternatives available are desirable. Values are involved in making these choices (Litwak and Hylton, p.397) and are important considerations in interorganizational studies and specifically for the health care field. Resources used to provide services of a certain quality in a specific area may mean services of another type are not provided. In the community it
is attitudes which are critical in determining where resources should be allocated. The universal and inescapable nature of this allocation problem is summed up by Warren (1967b) when he states "all societies must have a situation of partial conflict because of limited resources for maximizing values simultaneously" (p.410). Further to this "the community interorganizational field (is unable) to calculate rationally the optimum mix from a field of competing values ..." (Warren, 1967b, p.412). Regardless of the availability of resources there will always exist value conflicts, for it is impossible to determine the best possible mix or investment in various values. Given limited resources and conflicting values the phenomenon of satisficing is evidenced. Community resolutions and decisions regarding resource allocations are usually made in accordance with a consensus of community values (Warren, 1967b, p. 415). Complete satisfaction is never realized by all concerned as satisficing denotes reaching a mutually agreed upon compromise without totally rejecting available alternatives (Turk, 1973a, p.14).

Authority is discussed in the interorganizational context on several levels. Benson discusses authority in resource terms as the legitimate "right and responsibility to carry out programmes of a certain kind" and that "legitimated claims of this kind are termed domains" (p.232). This present discussion is concerned more with pointing out that interorganizational relationships are
most frequently found to occur without any formal or hierarchical structure (Turk, 1973a, p.38: Clark, p.234: Litwak and Hylton, p.398). Authority is seen to be related to organizational autonomy. Organizations are able to involve themselves with other organizations without necessarily compromising their autonomy because decision-making authority remains with the individual organizations.

Warren (1967b) sees decision-making in interorganizational relationships occurring within a four level continuum consisting of the federation, the coalition, social choice, and unitary contexts. A federation of organizations requires some commitment on the part of organizations but authority for ratification of decisions remains with the individual organization. The coalition context allows that an organization will have its own set of goals but will collaborate informally and on an ad hoc basis where some of its goals overlap those of other organizations in the coalition. The social choice context provides that an organization exercises the maximum amount of authority. Interorganizational structures do not apply because the organization exercises total control over all decisions (p.p. 403-408).

A fourth context for organizational decision-making that is identified by Warren is described as a vertical relationship where decision-making and authority descend within a structured hierarchy. Although this form is not afforded much importance by
the authors previously cited, it is seen by this writer to be central to this study. There is, in the literature, a tendency to ignore the circumstances of agencies of governmental authority. These agencies may be viewed as autonomous groups at the local community level where, because of their remote location from the central authority, they are able to act in some ways as though they were independent. However, there may, in fact, exist a unitary perspective within which local agencies are functioning. The governmental or central authority will view the organization in this context as a dependent organization striving to meet the goals of the central authority (Warren, 1967b, p.404). The local community agency may thereby be operating in a situation where it is perceived by local groups as autonomous while at the same time it is subject to vertical decision-making from a central authority. It is to be expected that in this situation members of local organizations may feel torn between locally identified goals and the need to remain loyal to the central authority. As Klein (1968) states:

Governmental agencies are subject to legal requirements and restrictions that make it difficult for them either to offer services that are adequate in the eyes of the voluntary agencies or to modify programmes in keeping with the plans of a local coordinating council. Among areas affected have been community health programmes, usually under government auspices and often, there-
fore, not readily integrated with the work of the voluntary family, child care, and other social agencies. Mental health is being sponsored and financed by government. Because of this, it, too, is less easily integrated within traditional health and welfare council patterns (p.168).

It is important to note that none of the contexts of organization decision-making identified by Warren are mutually exclusive of the other as an organization may be involved in one or all of these contexts at any one time.

Domain Consensus

Domain consensus is defined as "agreement among participants in organizations regarding the appropriate role and scope of an agency" (Benson, et al, p.51). "Each organization has its own legitimated segment of interest and operation ..." (Warren, 1967b, p.409). This agreement can be formally or legally defined as in the case of governmental agencies and institutions with legislated programmes or in the case of contractual agreements (Clark, p.234). In other instances the agreement may be informal, consisting of implicit understandings between organizations as to which goals are to be pursued by which organizations (Levine, White, and Paul, p.1191).
Lack of clarity of the respective domain of organizations may lead to conflict between organizations. Intrusion upon the prerogative of one organization by another, or lack of performance within one's domain may result in conflict. That is, just as an organization may be criticized for intruding upon another's domain, criticism may also be forthcoming if an organization is viewed by others as not fulfilling its mutually acknowledged responsibilities (Levine, White, and Paul, p.1191).

There also exists the possibility that lack of clarity over domain may affect relationships between more than two organizations. If two organizations are operating in similar areas of responsibility other organizations may have difficulty in differentiating between their respective functions (Levine, White, and Paul, p.1194).

In another vein Arnold and Hink, and Benson (p.238) acknowledge that conflict may result from efforts to coordinate activities of different organizations as these coordinative efforts may be seen to threaten an organization's domain. Arnold and Hink, however, also note that the opposite is possible; cooperation can be the outcome (p.462). It may be that coordinative efforts assist in sorting out organizational domains (Benson, et al, p.53).

Benson addresses domains in relationship to acquisition of resources in stating that "authority and money flow to an agency
on basis of its sphere of activities ..." (p.236) or, in other words, on the basis of the amounts and kinds of resources that they are able to justify (Benson, p.238). If achieving coordination among organizations requires a change in an organization's sphere of activity this coordination will have greater likelihood of being actualized if the required changes do not threaten resource availability (Arnold and Hink, p.462).

Interorganizational Coordination

Coordination of services is frequently cited as a major goal for mental health organizations but one which is extremely difficult to realize (Klein, 1968, p.166). The reason for pursuing this goal so ardently is to make more efficient use of the limited resources available by eliminating unnecessary duplication and overlap of services (Warren, 1970, p.114: Coates, 1974, p.1687: Goerke, 1964, p.713). Klein (1968) says that coordination will always remain a difficult achievement because it requires a forfeiture of organizational autonomy (p.54). This autonomy, as has been noted elsewhere in this review, may be compromised because of the relative inaccessibility of resources and an organization's need to acquire same. However, coordination of organizations may require that autonomy be given up for reasons that cannot be rationalized in resource terms. In such a case a choice based on organizational and individual values is
made which may preclude a coordinated effort on behalf of the concerned organizations (Kovar, 1970, p.145). Indeed, conflict between organizations often arises as a conflict over values especially if the values in conflict are both desired (Litwak and Hylton, p.396).

Lack of coordination does not signify the presence of conflict in interorganizational relationships nor is evidence of conflict an indicator of lack of coordination or cooperation. Interorganizational conflict then does not necessarily lead to the breakdown of interorganizational relationships, rather it is a required element (Litwak and Hylton, p.415).

Conflict between organizations is, as noted above, taken as a given in interorganizational relationships (Turk, 1973a, p.37; Warren, 1967b, p.410; Litwak and Hylton, p.397). Conflict is a by-product of organizational autonomy. The problem of coordination between organizations is essentially one of integrating intrinsic conflict with the need for cooperation.

Coordination between or among organizations must take into account that organizations seek to survive in terms that they view to be most favourable to themselves (Mott, 1970, p.56). This implies that organizations which coordinate their activities may, at different times, cooperate or compete with other organizations depending upon their particular view of the outcome.
Certainly this is a factor in determining if and when cooperation will occur (Thompson, 1970, p.157).

Warren (1970) suggests that competition between organizations may be a way of eliminating waste of resources and overlap of domains and that centralized coordination may not be the only avenue available to reach that goal. Duplication and overlap of services, he says, should not be discouraged. Rather agencies should be encouraged to close gaps in services and thereby maximize service to clients (p.127). He further suggests that this may be accomplished through a market-economy approach to provision of services (p.123). While Warren's approach would not necessarily be totally practicable or desirable (Kovar, p.136) the point it helps to make is that there is no one to one relationship (inverse or otherwise) between coordination, cooperation, and conflict.
The purpose of this chapter is to discuss and analyse factors identified in the research data as those aspects of specific organizations' internal characteristics which were seen to influence relationships with other organizations. Discussion centres on those factors which are viewed as being unique internal characteristics of individual organizations. The intent here is to discuss the various ways in which these internal characteristics affect the organization's relationships with other community mental health organizations.

Three organizations are selected for discussion here in order to present the clearest examples of identified factors within the confines of the existing data base. Similar factors which are identified in different organizations may affect the interorganizational relationships of these organizations in different ways. Where applicable, the apparent similarities or differences in the effects of like factors upon these interrelationships will be discussed.
Skeena Mental Health Centre

The Skeena Mental Health Centre, as a government agency, is an organization which is placed in a position requiring a certain fidelity to both its client relationships and to a central authority. In this instance the Mental Health Centre attempts to provide a service to people within a local catchment area while remaining under the jurisdiction of the more remote Provincial administration.

In these circumstances much of the internal structure of the Mental Health Centre appeared to be a product of the influence of the remote office and authority of the Provincial government, particularly the Division of Community Mental Health and the Civil Service Commission. As a consequence of this circumstance there is an apparent limitation on the extent to which the internal characteristics of the Mental Health Centre influence its organizational environment: that is, the Centre's ability to influence the central authority is limited.

For example, the personnel who staff the Mental Health Centre seemed to have resigned themselves to a position of ineffectiveness in some aspects of their relations with authorities in Victoria. Manpower and staffing issues in particular had been a concern in that for a period of nearly six months there had been only one staff member on line in the Centre. This person
was required to assume all administrative and service oriented responsibilities until additional staff could be recruited for the Centre. Obviously, without the necessary staff allocation there would be significant consequences for the internal fabric of the Mental Health Centre. In this instance the agency apparently had no alternative but to adapt to the circumstances. Services were discontinued to all centres outside of Terrace pending recruitment of additional staff.

However, it is evident that in this adaptive reaction the Skeena Mental Health Centre was able to influence the organizational environment in the Kitimat-Stikine Regional District. By exercising local authority to suspend services to areas outside Terrace, the Centre abdicated from its role as a major supplier of mental health services. The organizational domain that was ascribed to the Centre was thereby left in a vacuum of sorts. This perception was especially reinforced in communities which had been cut off from the Centre's services. In Kitimat, for example, the Kitimat Community Services Society prepared a brief to the Minister of Health which attempted to put forth the situation in which Kitimat was placed as a result of the suspension of mental health services. The brief, prepared by representatives from a number of community organizations, was intended to be a comprehensive document which would not merely request reinstatement of services from the Terrace offices of the Division of
Mental Health. More specifically it argued in favour of extended services for the community of Kitimat over and above those it had previously received. While it is true that in this brief the Kitimat Community Services Society presented a wider concern than the suspension of the services of the travelling clinic to Kitimat it is apparent, from interview sources, that it was the announcement of the suspension which precipitated the reaction of the Society.

It is the writer's interpretation that the above example shows that an organization does not necessarily have to be dynamic and omnipresent in its relationships with other organizations in order to influence their behaviours. In this instance a very non-aggressive role evidenced by the Mental Health Centre's withdrawal of services was enough to prompt a reaction in the organizational environment. While other agencies and organizations such as Public Health, schools, and churches may have taken up the slack to some extent, it is clear by the reaction that the domain of the Mental Health Centre was seen to be largely inviolate. The failure of the Centre to fulfill its social contract in this regard resulted not in other organizations assuming the vacated role, but in a protest that the agency should reinstate itself in this role and extend it to provide a more comprehensive service than the one previously available.
While to a large extent the decision to suspend services to outlying communities was externally imposed upon the Skeena Mental Health Centre by the failure of the Provincial government to provide adequate manpower resources, the internal authority of the Centre was still an important factor in the outcome. If no announcement had been forthcoming from the Centre and services had been provided to Kitimat, even on the minimal level, one wonders if the reaction from the Kitimat Community Services Society would have been so pronounced. It is a matter for conjecture, but it may be that it is easier to mount a protest against a total suspension of services than against inadequate services. The inertia may be more easily overcome in the face of a total withdrawal.

The Three Rivers Workshop

The Three Rivers Workshop is an independent organization in that there are no formal hierarchical relationships between it and other organizational bodies. Three Rivers was instituted through the efforts of the Terrace Association for the Mentally Retarded (T.A.M.R.) who secured initial funding through a Federal government Local Initiatives Project (L.I.P.) grant. However, T.A.M.R. did not retain control of the workshop. Once established, Three Rivers took on an autonomous nature in that planning
of programmes and facilities were under the sole jurisdiction of the workshop director.

Under the authority of the director, the workshop attempted to assume an expanded role as a training centre. Workshop policy became gradually entrenched which was intended to promote opportunities for independent living of workshop participants. A salary structure was instituted and a work experience environment was created.

Financial resources from L.I.P. grants were not viewed by the workshop director as being adequate for the needs of a training centre. In order to subsidize the limited funding provided by the L.I.P. grants the Workshop secured a five thousand dollar loan for woodworking equipment and began to manufacture a line of wooden toys for sale to the local community. It was intended that the sale of these products should be used to remunerate the workshop participants and that the manufacturing process would serve as a valid training experience for future employment of the workers in local businesses.

In fact, the experience of the Three Rivers Workshop was that there was an initial compassionate response from the community which provided a short-term market for the workshop product. While this community response facilitated the early retirement of the equipment debt, it became apparent that there was a limit to the extent of legitimate business. The assembly line
techniques of the toy manufacturing process were not easily diversified which resulted in the accumulation of large inventories of unsaleable toys. With the diminution of the market for workshop products the funding for Three Rivers once again fell to levels which were insufficient for the operation of a training centre. In addition, L.I.P. funding was terminated. Funding from Provincial government sources was available only in amounts which were sufficient, in the Provincial view, for the ongoing maintenance of an activity centre. This was not consistent with the aspirations of the workshop manager.

Attempts were made to acquire support for Three Rivers from local sources. These efforts ranged from requests for subsidized or rent-free facilities from the School Board to requests for make-work projects from local industry. It should be noted that five or six former workshop participants had apparently been able to secure employment in Terrace over the two year period during which the workshop was successfully marketing its products. In spite of this, officials of other community mental health organizations such as the Child Development Centre and the residential half-way house expressed concern regarding the limited programme and work-like environment of Three Rivers. In particular, the physically handicapped individuals found the environment stifling. There were problems in motivating people to attend the workshop on a regular basis because of the regimentation and lack
of scope in the programme. Indeed, as noted above, economic necessity precluded development of individualized or diversified activities in the workshop.

The recapitulation of the Three Rivers Workshop's operational history illustrates the need for establishing clear organizational goals and objectives. The facts, as represented above, serve witness as well to the importance of the leader's role in guiding an organization's destiny and its concomitant relationships with other organizations.

It appears that most of Three Rivers' organizational problems stem from the fact that the organization was established with a very loose framework and limited information. The manager, once appointed, had very little guidance from a parent organization or board of directors and was left largely to his own devices to operate the facility. Without the benefit of either experience or outside consultation, the workshop became the creation of an individual.

The community was requested to ensure the continuity of Three Rivers. While community support for the concept was quite strong, the increased involvement resulting from the support had a price. The community organizations began to evaluate the workshop role in terms of the availability of resources. If Three Rivers was to survive, its focus would have to conform to that which was defined by funding agencies. For example, the
local Community Resources Board indicated that it would support the Workshop if and when funds became available but that there would likely be a necessary limitation on the programming. (The Department of Human Resources had already stated that its funding policy would limit funds to levels which it deemed adequate for an activity centre.)

The organizational independence of Three Rivers, at least, in its local environment, had become somewhat circumscribed in that because the workshop was requested to patronize the organizations which controlled the resources, (or at least its manager) was obliged to compromise the orientation of the workshop programme.

It is clear that the community was virtually blackmailed into providing support for Three Rivers. The ambitious project was established on the basis of an unstable funding source (L.I.P. grant) and unless these resources dried up, an organization which had carved out a domain for itself, was left with its empty hand extended to the community. Even though the particular programme of the workshop was not widely endorsed within the community, it was acknowledged by even its most vocal critics that the service, or something like it, should be continued. The lack of internal planning, guidance, and/or experience thereby imposed a liability upon the local mental health
and social service agencies which had come to rely upon the workshop.

The Kitimat Workshop

The Kitimat Workshop commenced operations with the aid of a L.I.P. grant secured by the Kitimat Association for the Mentally Retarded (K.A.M.R.). In many respects its creation replicated that of the Three Rivers Workshop in Terrace. It also incorporated the notion of providing services to both physically and mentally handicapped persons. These similarities notwithstanding, the operations of the two facilities became diverged considerably with the passage of time. Much of this contrast is attributed to the internal structure and operations of the organizations.

The Kitimat Workshop has, from its inception, subscribed to an activity centre model in provision of services. Even in the face of what was described, in an obvious understatement, as inadequate funding (the initial Federal L.I.P. grant was suspended and the application for a Provincial government Activity Grant was later refused) there was no active consideration of attempts to become self-supporting. Generation of funds through sales of craft items had been attempted on a very limited basis, but was discontinued in view of limited community response.
The likelihood of a total absence of external funding diminished the initiatives of the Kitimat Workshop personnel and that of the founding group. Staffing of the workshop and participation of clients fell markedly over a one year period. This was due, in part, to relocation of some persons (staff and clients) away from Kitimat and physical illness of others. The committee responsible for monitoring the workshop had not communicated plans to the workshop staff for future operations of the workshop in view of suspended funding. The only impetus within the group came from a parent of a mentally retarded child. (The child, at that time, was a student in a special education classroom. Her mother was anxious that she should be attending the workshop in the coming year.)

The physical surroundings of the Workshop left a great deal to be desired. It was located in the sub-basement of the Kitimat General Hospital. Access was by use of stairs. The walls, floors, and ceiling consisted of bare concrete. There was a low ceiling and light was provided by bare incandescent bulbs. The location was difficult to reach for the severely physically disabled people who were intended to form part of the clientele.

The consequences of the above circumstances upon interorganizational relationships are such that the relative inactivity of the workshop precluded extensive and meaningful interaction with any external body. With funding alternatives apparently
completely exhausted, it was doubtful that the workshop would be able to continue operations beyond the limits of its existing financial reserves.

It was evident that any potential for interorganizational relationships was not being pursued. Indeed, throughout the short life span of the organization there was little evidence that the workshop had had relationships with many of the organizations at the local level. One of the causes or factors contributing to that low profile may have been the rather limited enrollment of workshop participants. The size of the organization, in terms of numbers of clientele served, may have been too limited to give the organization credibility. Certainly this was a factor in the Provincial government's decision not to fund the Workshop, there being too few clients in regular attendance to warrant Provincial support. At the local level, the credibility of the organization may have suffered as well because of the limited qualifications and programming skills of the workshop leaders. After the departure of the initial organizers to Vancouver, there was very little expertise available. The interest of the workshop committee and clients began to wane. The activity of one person who, as a parent of a mentally retarded child, regarded the workshop as the only alternative for her child after leaving a special education classroom did not seem to be able to generate much concern within other community organ-
izations. The only discernable reaction was one of detached acknowledgment on behalf of representatives of the Kitimat Community Services Society.

The Kitimat Workshop was in serious financial straits and would, in the estimation of the people involved in the Kitimat Community Services Society, likely be required to suspend operations.

The above example of the Kitimat Workshop shows not how interorganizational relationships have been affected but rather how they have been negated because of internal characteristics. The workshop was unable to attract and retain participants and without these the workshop suffered. Clients in this sense may be argued to resemble resources, without which there would be no organization.

The leadership of the organization was identifiable. The workshop director ascribed much of the impetus of the organization to a parent who clearly had a vested interest in the continued presence of the workshop facility in the community. No matter what the incentives of the organization's leaders, there were very few options available to pursue which would ensure the future operation of the workshop. The funding of organization from Federal and Provincial sources had been exhausted. Neither was the support of the community seen by the workshop director or the concerned parent as a realistic alternative. The profile of
the organization was too limited and without the ability to demonstrate need for the service, local agencies and organizations simply had no reason to interact with it.

Analysis

As mentioned in the introduction to this chapter, only three organizations have been chosen for development of Level I analysis of interorganizational relationships. The reason for this is simply that information regarding internal characteristics of other organizations was not readily retrieved from the interviews and research data. Nonetheless, even with a small sample of organizations it is clear that internal characteristics can be shown to affect the nature of interorganizational relationships.

A summary of the points brought out in these examples is presented here to illustrate the significance of the five major variables discussed in Chapter III of this study.

Resources

Resources and their effects upon interorganizational relationships are particularly germane to the discussion of internal characteristics of organizations. As described elsewhere in this study, resources can take on many different forms.
Within the organizations discussed above it is possible to identify specific resources which are associated with internal characteristics and which affect interorganizational relationships.

Manpower, as a basic resource, is a commodity which is of critical importance for the internal workings of all organizations. It is not manpower in and of itself that is critical, but rather the characteristics of that manpower. Knowledge, experience, and common sense are valued resources for an organization which are present in greater or lesser amounts within an organization's manpower base. In both the Three Rivers and the Kitimat Workshops, certain of these attributes were found wanting in both the managerial and programming staff. The consequences have already been documented.

In the two workshops above, examples of manpower resources pertain to qualitative characteristics. In the case of the Skeena Mental Health Centre, manpower as a resource took on a quantitative perspective. Because available manpower was diluted to the point where services were provided by a single person inadequate resources were available.

A second quantitative context and one which has been alluded to previously is the relative availability of clients to receive services. In the Workshop environment, it may be argued that the clients, as workers, are component parts of the organization. If this argument is accepted then it is possible to contrast the
Three Rivers Workshop which had plentiful client resources to the Kitimat Workshop which had been virtually starved for client participation.

Other basic resources, such as funding (capital), land (physical facilities), and technology (organization) were not seen to have a strong influence at the internal level upon the nature of interorganizational relationships. However, some observations can be offered in these contexts. It appears that the relative availability of any resource could influence the structure of an organization and the ways in which it relates to its environment. For example, Three Rivers Workshop, in response to inadequate funding, developed a mass production line of toys, the sale of which would generate income for the workshop's programmes. In addition, the workshop was criticized for an apparent inadequacy in its programme (poor treatment technology) which deterred some people from attending on a regular basis. A drop in numbers of participating personnel could have an impact on the ability of the workshop to generate income and/or restructure its programme. That is, there would be a reduced productivity and a possible change in programming for economic reasons. This change might not reflect the needs of clients participating in the Workshop's programmes. Further speculation on this point is not warranted here. It shall be shown in subsequent sections of this discussion that resources are inex-
tricably involved in influencing other variables which effect interorganizational relationships.

Power

Power in interorganizational relationships at the first level of analysis seemed to take at least one of the characteristic forms described earlier in this study.

The case of the Skeena Mental Health Centre was an illustration of an organization exercising a legitimated authority over the extent to which its services were provided. The services were withdrawn from outlying areas on the prerogative of the administrative staff of the Centre. This action clearly could be seen to affect the orientation and behaviour of other organizations located in an area which was no longer receiving service. The only qualification here is that there was no control exercised by the Mental Health Centre over the reaction of the other organizations. It cannot be assumed that the particular reactions of organizations could have been predicted in any fashion by the Mental Health Centre. Therefore, it is seen that while there was power to withdraw services, there was no power to control any reaction that might arise from that withdrawal.

This example seems like a simple demonstration of an organization's ability to exercise its administrative prerogatives.
However, this in itself is an expression of power inasmuch as the control of the Mental Health Centre's services lie, at least to some extent, with the bounds of the local administration. Although the Centre's resources were severely limited by an external authority, there still remained a capacity to control their distribution on a local level.

A more subtle kind of power may be argued to have been evidenced in the example of Three Rivers. Here the power may be seen to lie in a moral context in that the Workshop, having once established itself as credible and useful agency in the community, was able to convince both local and governmental bodies that its continued existence was worth supporting. Certainly within the local community the economic plight of Three Rivers was sufficient to elicit compassionate financial relief.

This kind of power is reasoned to have evolved from internal characteristics of the organization in the sense that the management was responsible, in part, for the particular economic circumstances. Over and above this, Three Rivers, by virtue of being involved in providing a direct service to the mentally handicapped, would command a charitable response from society which, in turn, might be reflected in the behaviour towards Three Rivers of other local organizations.

Perhaps more importantly, Three Rivers was the only centre of its type available to the local community. Power is also
assigned to any organization which provides the only source for a particular service.

The Kitimat Workshop seems to possess little or no power which can be ascribed to its internal characteristics. There was, it would appear, a limited need for the services of the workshop. Its services were not in high demand if one uses the attendance rate as an indicator. The expertise within the organization was limited in regard to both managerial and programming skills of the director and the managing committee.

Although the Workshop might have expected some compassionate response from the community (as was received by the Three Rivers Workshop in Terrace), it was obvious that none was forthcoming. This may have been due again to the fact that so few clients were enrolled in the workshop programme and also in part to the low profile of the workshop director and managing committee.

Organizational Autonomy

Organizational autonomy is an area which appears to be highly dependent upon internal characteristics of organizations and in the cases at hand is seen to be closely identifiable.

With regard to the Skeena Mental Health Centre there is a dichotomy in the autonomy of that organization. On one hand the Centre controlled in a vertical relationship with a central
authority in Victoria. On the other hand, it was able to unilaterally and formally discontinue services to certain areas in its assigned jurisdiction. In this situation, the agency is afforded a degree of autonomy in its relationships at the community level, but this autonomy is subject at all times to a central authority. The implication being that the limits to the autonomous nature of the organization may not always be visible to other organizations at the local level. Furthermore, those limits may not be known, even to the local organizations, until they are tested by some direct action.

The Three Rivers Workshop may be described as having possessed different levels of autonomy at specific periods in its existence. Initially, the organization was able to exercise considerable autonomy as it was virtually independent in terms of resource management. However, this autonomy appeared to diminish rapidly as the organization became more dependent upon other funding bodies. Autonomy was compromised in order to obtain more secure funding. Funding agencies began to indicate that funding would be available only in amounts sufficient to sustain programmes they themselves defined.

The Kitimat Workshop had always been autonomous although it was evident that autonomy would have been willingly surrendered for adequate funding. In the end, there was no support for the workshop, few relationships with other organizations had been
formed, and resources were not available in any form. Autonomy was retained, but this was of no benefit to the workshop.

**Domain Consensus**

Domain consensus does not seem to be particularly germane, at least in the examples at hand, to internal features of organizations. However, some limited observations are required.

In the case of the Skeena Mental Health Centre, the organizational domain is seen to be authorized by virtue of a legitimated authority. The terms of reference and parameters of service are the product of a Provincial government mandate issued by the Division of Community Mental Health. It is possible, however, that within the unique environment of various communities that certain areas of responsibility may be negotiated by organizational representatives. If such negotiations were to take place, it is again possible that it would be influenced by internal traits of the negotiating organizations.

In the matter of the Three Rivers Workshop, however, there is some evidence that an attempt to influence the agency's domain may be attributable to internal characteristics. As noted previously, the director of Three Rivers was able to exercise considerable control over the emphasis of the workshop programme. It was his strong personal belief that the workshop should be a
training centre. In the absence of any conflicting opinions, the attempt was made to establish the training centre. However, when other organizations became involved with Three Rivers it was clear that there was no consensus about the workshop role. In the final analysis, it was never resolved what the workshop should be doing. In spite of the constraints imposed by funding agencies, the workshop director was still determined that the main emphasis should be upon training of clients. Consensus may have been achieved in the sense that funding was in fact being provided on the basis of a more limited sphere of activities.

In the case of the Kitimat Workshop, the absence of funding and authority indicated that there was no domain consensus. In fact, there was no domain being recognized by funding bodies. Again, whether or not this is attributable to any internal characteristics other than limited clientele is not clear.

Interorganizational Coordination

Interorganizational coordination was not seen as a major factor which was influenced by interorganizational relationships at the first level of analysis. No evidence was obtained from the research data to bear out a relationship between internal characteristics and levels of interorganizational coordination for purposes of eliminating unnecessary duplication and overlap.
of services of different organizations. This is not to say that no relationship exists. In the examples at hand there were no problems of coordination of services because each organization operated within a limited sphere and was not seen to overlap services offered by any other organization.
The purpose of this chapter is to discuss and analyse factors identified in the research data which were seen to be of primary importance in influencing relationships between organizations. As described in an earlier chapter, at Level II the focus is upon a single organizational entity and its relationships with other organizations comprising its organizational environment. In this chapter, several organizations will be reviewed in this context and relevant factors affecting the nature of their relationships with other organizations will be discussed.

Because, at Level II, it is the individual organizational unit which is the object of direct concern, each of the organizations will be described and then discussed in turn under each of the five major dimensions chosen for analysing Level II inter-organizational relationships. The organizations which are discussed are arbitrarily selected by the author so as to permit broad development of the available research data.
The Osborne Guest Home was a fairly new addition to the community mental health organizational environment in Terrace. At the time the data collection for this study was being conducted, the guest home had been in operation for approximately six months. During that period it had successfully established itself to the extent that it was able to provide treatment programmes on an individual basis for a full complement of residents. Relationships with other organizations in the community had been placed on a positive footing from the perspectives of both the administration of the Guest Home and those persons who represented other community mental health organizations in Terrace. Furthermore, adequate and consistent funding for the home had been secured from two sources. Capital funds had been obtained from a local organization, the Skeenaview Society, and the operational budget had been secured from the B.C. Department of Human Resources. Osborne Guest Home was placed from the beginning on a very favourable operational foundation.

Several factors may be seen to contribute to this apparent organizational well being. The historical context of the creation of Osborne Guest Home provides important insights. It had been argued for sometime by many of the local health and social services professionals that there was a great need for a resid-
ential boarding house for psychologically and physiologically impaired adults in the Terrace region. In acting upon this commonly acknowledged deficiency in health care programmes an aggressive campaign was launched by the clinical administrator of the Skeena Mental Health Centre. This campaign had the tacit, if not active, support of much of the professional manpower in the region. Even the lay public were motivated to support the cause through their participation in the Skeenaview Society which provided the necessary capital funding for the Home.

It is understandable therefore, that there should be a general good will surrounding the Osborne Guest Home. To a very real extent it was the product of the efforts of the local community.

Another factor which would seem to lead to positive relationships between Osborne Guest Home and other organizations in the community was evidenced in an examination of the membership of the admitting committee. The committee was composed of representatives from the Public Health Unit, the Skeena Mental Health Centre, the Department of Human Resources, Aid to the Handicapped, local physicians, and the Executive Director of the Home. When one considers that referrals to the Home had come from Skeena Mental Health Centre, the Department of Human Resources, institutions such as Riverview and Woodlands, as well as from three of the local physicians, it is obvious that most of the
potential sources of referrals have representation on the admitting committee. Such pragmatism in the committee structure should have left many of the representatives in a position to ensure that their organizational interests, at least in terms of patient or client referral, were given equal time with those of other referring agencies.

Another associated result of the wide involvement of local community agencies in the operations of the Home is an enhanced understanding on behalf of the Home's administration of the operations of other agencies. For example, while there was a feeling that client contact and follow-up of referrals from the local personnel of the Department of Human Resources was left wanting in terms of frequency there was some sympathy extended towards the staff of the Department. The staffing complement was too small to meet the regional demands, the Home administration thought. Because the Home provided a rather stable environment in terms of support for the clients residing there the Department was able to reduce its level of service to those clients in order to provide needed services elsewhere. The staff at Osborne Guest Home acknowledged their own ability to compensate for the reduced contact from the Department of Human Resources and thereby gave tacit approval to the unofficial strategy of the Department. A somewhat cynical note which was never brought up is that it may
also have been easier to compensate for the perceived under servicing from the staff of the Provincial department which provided the operational budget to the Home.

An agency which did not receive the same kind of empathetic response from the Osborne Guest Home administration was the Three Rivers Workshop. The relationship between these two organizations could have been more positive than it appeared to be. Many of the residents of Osborne Guest Home required or at least could have benefited from a sheltered workshop and/or training programme such as that which Three Rivers was trying to develop. Similarly, in order to remain a viable organization providing programming for mentally and physically handicapped adults, Three Rivers required participants in its programme such as those people who resided at Osborne Guest Home.

However, many of the residents at Osborne Guest Home were reluctant to go to Three Rivers Workshop because of the routinized nature of the programme there. It was said to be too boring. This led to frustrations within the Osborne Guest Home. Residents of the Home chose either to remain at home or to attend on a sporadic basis. Programme efforts and motivation of patients were more difficult for the Home's staff. Their own resources became taxed when outside programming, such as that at Three Rivers, proved inadequate for the residents. The dissatisfaction at the administrative level in the Home was voiced by
the Executive Director of the Home. In spite of knowledge of the
nature of internal problems at Three Rivers, there was little
tolerance for the situation. The Home's staff relied upon the
availability of the Three Rivers programme but found it unac­
ceptable in its existing format. Thus, what could have been a
strong, positively reciprocating relationship between the two
organizations suffered because of the failure of one organization
to live up to the expectations of another.

Skeenaview Lodge

The Skeenaview Lodge is an organization which has seen many
significant changes over approximately twenty-five years. It was
opened in 1951 as a 300-bed psycho-geriatric unit and was oper­
ated largely as a depository for British Columbia's male chronic
care patients. Its administrative centre was located at Valley-
view and virtually all policy decisions emanated from that
institution.

As Skeenaview endured in Terrace its importance to the
community as an "industry" was established. In 1968 the local
community successfully lobbied the Provincial government to
abandon plans to phase out the centre.

In a strictly organizational context the most significant
change occurred in 1972. In June of that year, initiatives were
begun to turn the management of Skeenaview over to a local Board of Directors. The intention was to convert Skeenaview into a regional facility for both men and women. The transfer of authority took two years and on May 1, 1974, Skeenaview was turned over to the local society for a trial period of one year.

Since June of 1972, major changes were made in the operation of the lodge. Staffing was increased from 74 to 137 in 1975. All functions except the printing of paycheques were turned over to Skeenaview. Admissions are accepted only from the north and remotivation and rehabilitation have become the central focus of a wide variety of treatment programmes.

The rehabilitation of Skeenaview as an institution has been dramatic. An important factor in changing its image was the establishing of a Board of Trustees which involves Terrace residents in the management of the Lodge. As well, a young hospital administrator with great concern and initiative took over the running of the organization in 1974. Together, the Board members and the professional staff, transformed the Lodge, within the limits of available resources, from a custodial care institution to a bonafide therapeutic and rehabilitation centre for psychogeriatric care.

Because Skeenaview was cut off from the local community in the earlier days and because the present emphasis in mental health care was towards greater community participation, very
great efforts were made to link Skeenaview more closely with the rest of the community. Meetings of professionals were held in the boardroom, visitors encouraged, and Skeenaview provided Meals-on-Wheels and catering services for senior citizen activities.

It has already been noted in the previous section dealing with the Osborne Guest Home that the Skeenaview Society took considerable initiative in organizing funding for the Home. This intense activity and energy directed towards community linkages has obviously had a great impact upon the interorganizational relationships between Skeenaview and other community mental health care organizations.

The relationship between Skeenaview and the Terrace Community Resources Board is particularly relevant to Level II inter-relationships. There are two instances which sharply illustrate this claim. Firstly the Community Resources Board Meals-on-Wheels programme was supported significantly by the resources of Skeenaview Lodge. All meals sent out to the community were prepared by personnel of Skeenaview using Skeenaview's equipment and food stuffs. Regular production of meals by Skeenaview personnel was simply expanded to include the required number of meals for the Community Resources Board clients.

Secondly, the Chairman of Community Resources Board was the Administrator of the Skeenaview Lodge. A strong personal in-
terest, on his behalf, in the operations and development of the Board no doubt accounted for the strong support of the Meals-on-Wheels programme.

It is important to note that the Community Resources Board as an organization is not concerned solely with the field of community mental health. However, other social services organizations such as the Three Rivers Workshop and the Child Development Centre were slated to receive some financial support from the Board if and when the Board was given funding authority from the Provincial government. In an indirect way then, the Board served as a channel of communication through which at least the Administrator of the Skeenaview Lodge could develop relationships with other community mental health organizations.

Skeenaview Lodge, at the time of the study, was an organization which seemed to be thriving on its new programme innovations. While community relationships were only just beginning to be formulated it was evident that the administration of the Lodge was keenly interested in establishing relationships with the local community.

The Terrace Association for the Mentally Retarded

The Terrace Association for the Mentally Retarded (T.A.M.R.), as a voluntary organization involved in community mental health
services, offers some interesting opportunities for discussion of Level II interorganizational relationships. A primary distinction between T.A.M.R. and other organizations discussed to this point in this study is that T.A.M.R. did not provide services directly to clients. Rather it was an organization which attempted to develop and support community mental health care programmes to be run by other organizations.

It was reported by members of the T.A.M.R. executive that the organization had been successful in promoting the development of several community mental health programmes in Terrace. It was the T.A.M.R. initiative which secured the initial L.I.P. funding for the Three Rivers Workshop. They also were successful in raising initial funding for the purchase of the Alice Olsen Home facilities. Relationships with both these organizations were the principal concerns within T.A.M.R.'s organizational environment according to the executive members. Indeed, the organizational objectives of T.A.M.R. were oriented to establishing residential facilities in Terrace to house mentally handicapped children from in and around the Terrace region. Priorities were equally weighed between providing two facilities, one for young children and one for adolescents.

A representative from T.A.M.R. served with individuals from Skeena Mental Health Centre, the Public Health Unit, the Department of Human Resources, and the house parents of the Alice Olsen
Home on an admissions screening committee for the Alice Olsen Home. The T.A.M.R. representative was a local physician who consulted with parents regarding their decision to apply to send their children to the Home.

The Terrace Association for the Mentally Retarded did not have a very large sphere of organizational activity. The most constant relationships were evidenced between it and the Alice Olsen Home and the Three Rivers Workshop, each of which T.A.M.R. was centrally involved in establishing. Other relationships were seen to develop vicariously through these more direct linkages. Specifically, the relationship between T.A.M.R. and the local offices of the Department of Human Resources was enhanced through the direct concern of each with the Alice Olsen Home. Both organizations made referrals to the Home and both had interests in its continuing operations. Similarly relationships between T.A.M.R. and Skeena Mental Health Centre centered around mutual areas of activity although direct formal contact between the two organizations was limited. There was an area of overlap in the counselling function. Many parents of mentally retarded children were seeking the assistance of T.A.M.R. members who were themselves parents of mentally retarded children. It was thought that advice flowing from people who have faced similar problems often has more meaning to the uninitiated party. For this reason Skeena Mental Health would frequently suggest to parents seeking
their counsel that it could be of additional benefit to seek out more personal advice from the lay membership of T.A.M.R.

It is interesting to note in addition to the fostering of vicarious organizational relationships that there was a screening process of sorts at work. The Alice Olsen Home for instance had a strong relationship with T.A.M.R. as a founding and referring body. However, an equally strong relationship was formed between the Home and the Jack Cook School. Attendance at Jack Cook School was a compulsory condition of residence at the Home. However, this relationship notwithstanding there was never any mention by T.A.M.R. officials or the School principal of any formal ties between the two organizations. The school's administration and programming were not, apparently, a concern of the T.A.M.R. membership although many of their own children were in attendance there. This observation is made only to point out the possibility that the T.A.M.R. membership may have individual priorities such as school for their children and at the same time they have have a collective priority such as boarding home facilities for mentally retarded children who are not necessarily their own. It may be that the collectivity, recognizing a need for complementary facilities, focused only on the unmet need it perceived in an attempt to build a network of facilities that would fill gaps in the community mental health care system.
It should be noted that T.A.M.R. has received considerable assistance and guidance in its activities from the British Columbia Association for the Mentally Retarded (B.C.A.M.R.). While the nature of this assistance was not made explicit it may be that the support of that provincial organization provided T.A.M.R. with some measure of local credibility, especially in its relationships with government organizations such as the Skeena Mental Health Centre and the Department of Human Resources.

Indeed the aspect of fund-raising by T.A.M.R. has been closely allied to the provincial association's annual Flowers of Hope campaign. This has resulted in consistent funding over the recent years. Additional funds for specific projects have been quite readily obtained from various service clubs in the community. From a financial point of view then T.A.M.R. regarded itself as solvent and even prosperous and did not need to rely on any other local organizations for its continued existence. Rather it saw itself as a source of funding rather than as a resource user and consequently felt quite independent of other local organizations.

**Child Development Centre - Kitimat**

The Child Development Centre in Kitimat was an organization which had developed organizational relationships between itself
and various local and non-local community mental health organizations.

An important non-local relationship existed between the Centre and the British Columbia Cerebral Palsy Association located in Vancouver, B.C. This relationship stems back to the time of creation of the Child Development Centre when the provincial body provided assistance in securing initial budgeting, making grant applications, locating staff, and developing a suitable organizational framework. Since then the B.C. Cerebral Palsy Association had continued to provide annual grants of money to assist in the continued operation of the Centre. In 1975 this annual grant amounted to $20,000. The other services continued to be provided as well. Particularly useful to the Child Development Centre was the assistance in locating manpower for professional positions within the Centre. The relationship between the Centre and the provincial Cerebral Palsy Association was viewed very positively by the Centre's Board of Directors and was essentially one of gratitude for the initial assistance in helping the Centre establish operations.

Another non-local organizational relationship noted was that between the Kitimat Child Development Centre and the Terrace Child Development Centre. Although this relationship was not described in great detail by representatives of either organization, the description that was given did establish that the
relationship was based upon a mutual sharing of staff. A highly qualified speech therapist was recruited and funded jointly by the two organizations. It was not obvious that relationships between the two organizations proceeded beyond the shared funding. No reference was made to any other organizational exchanges. The fact that a regional pediatrician served as medical director for both facilities was not seen by the Kitimat Board Chairman as constituting a formal organizational linkage. Any interaction between the organizations which was mediated by this physician was apparently informal and spontaneous.

At the local level, interorganizational relationships between the Child Development Centre and other community mental health organizations were evidenced and were identified by their representatives as being of great importance to the operation of the Centre. For example, the linkage with the Kitimat Association for the Mentally Retarded was cited by the Child Development Centre's Board Chairman as being a strong tie. The nature of this relationship was essentially a duality of membership. That is many of the people who were members of the Kitimat Association for the Mentally Retarded were also involved with the Child Development Centre.

While the implications of this double membership and/or representation could have been important to both organizations, it was difficult to detect any major influences that affected the
organizational character of either group. The Child Development Centre and its Board were operating a well funded, well thought out, and viable organization while the Kitimat Association for the Mentally Retarded was struggling desperately to preserve the existance of the Kitimat Workshop. However, there was some evidence of a blurring of the relative jurisdictions between the two organizations. The fact that the Child Development Centre was hopeful of offering programmes in the future to educate mentally retarded children does seem to be an indication of more than a passing interest in the welfare of the mentally retarded.

In a similar view, there was mention of both organizations being hopeful of acquiring newly vacated space in a centralized building complex. The Child Development Centre did not expect to be given access to this space given the plight of other groups such as the Kitimat Workshop. There was some sympathy for the situation of the K.A.M.R. sponsored facility but there was little opportunity to provide support for their application. In fact, it seemed likely to officials at the Centre that neither application would be approved.

At the local level it appeared that there were two other organizations which the Child Development Centre regarded as constituting a major part of their organizational environment. The first was the Public Health Clinic. This relationship seemed to be most important to the actual operation of the Centre in that
the Public Health Nurses were seen as referral sources. It was the opinion of the Administrator of the Centre that one role of the Public Health Unit should be to go into the community and to ferret out and refer potential clients to the Centre. While this role seemed not to be fulfilled to the satisfaction of the Administrator, there was evidence that information about the Centre and its programmes had been made available to the Public Health Nurses. They had made several referrals to the Centre in the past and were in frequent contact with the staff at the Centre. Still it was felt that more could be done to help the nurses to recognize the early indications of disability in children and thereby assist in more effective treatment for more children. Other than continuing the present liaison practices, there was no indication as to how the personnel at the Child Development Centre would be able to affect an increased awareness in the local nursing staff.

The other organization with which the Centre had developed an important relationship was the Kitimat School District No. 80. There was an implied expectation on behalf of the Centre that children should be able to make a transition from the programming at the Centre to special classroom facilities operated by the School District. A continuum of educational programmes should be available in the local community which would or could permit children to progress from pre-school training at the Child
Development Centre right on through to participation in normal school programmes. The relationship between the Centre and the School District however, was not well defined at the time of the study. Several references were made to the potential for integrating the Child Development Centre programming with that of the School District but there had been no formal linkage between existing programmes run independently by these organizations. It was mentioned that a teacher for deaf children had recently been hired jointly and that this was the first time such a coordinated effort had been achieved between the two. In light of that development it is evident that there was a recognition by both groups that there were opportunities for stronger and more formal organizational ties.

**Analysis**

The foregoing examples of specific Level II interorganizational relationships provide several opportunities to analyse the ways in which resources can affect relationships between organizations.
Resources

The Osborne Guest Home provided an opportunity to examine aspects of the affects of resources which were not as clearly distinguishable in the experiences of other community mental health organizations in Terrace. Most resources such as funding, physical facilities, and professional manpower were being or had been provided on a stable basis. The clientele being served were even flowing into and out of the programmes of the facility on a regular basis. This description serves to imply that the technical organization of the Home was working well. In most respects the Home was interacting with members of its organizational environment in a well coordinated fashion.

The organizations which had collaborated in establishing organizing and funding the Home were being given fair exchange for their investment in that virtually every organization which had provided assistance was now afforded the opportunity to refer clients to the Home's programme. The Osborne Guest Home became a direct resource for the activities of organizations which had facilitated its establishment. The resource providers, it seems, had created an organization with which they intended relationships would be maintained to the mutual advantage of all concerned. This is evidenced in the fact that so many of the founding organizations had representatives on the Admission
Committee for the Home. Clearly the Home's primary organizational relationships had not changed appreciably since its creation, especially in terms of the members of the organizational environment. The resources which other community mental health organizations had invested determined to a large extent the orientation of the Home in its relationships with those organizations, at least insofar as the admissions to the Home were concerned.

Resources can also be seen as influencing the relationship between the Home and the local offices of the Department of Human Resources. As noted previously the clients who were referred to the Home were not given as intense follow-up and support by the staff at the Department because the Home was regarded as being relatively well off in terms of professional staff and programme activities. Because of the quality and quantity of resources of the Home the Department chose to invest their own specific resources, such as staff time, elsewhere. This was accepted by the Staff at the Home who recognized that the relative strength of their own programming and at the same time saw that the resources of the Department were not adequate to meet the demands being placed upon them. In this instance the resources available to both organizations can be seen to influence the nature of their relationship. While this can be said of most interorganizational relationships where one organization has resources while the
other has not the distinction here is that the resources are not elements to be exchanged. The organizations can function independently to a great extent and were they given more abundant resources the nature and frequency of their interchanges would likely be increased. However, under circumstances of limited resources of one organization and the relatively abundant resources of the other a mutually agreed upon level of exchange was established.

The Skeenaview Lodge, as an established organization, had had access to sufficient resources of various kinds to maintain operations for a period of more than twenty years. In that period the resources at hand had been utilized primarily to sustain the internal functions of the Lodge as it housed and treated the chronically mentally ill. The basis of most of its organizational relationships was with organizations outside Terrace. Funding, staffing, patients, policy, and authority sources were all externally located. In spite of the geographic remoteness of the Skeenaview facility from resource centres such as the Provincial government and other psychiatric facilities in the province there remained a primary orientation of the facility to the sources controlling the resources of the Lodge. There were few, if any, interorganizational relationships between Skeenaview and local mental health organizations. The Lodge did, however, become an "industry" in the community and as such con-
tributed to the economic fabric of Terrace. Over time, the community's economic dependence upon the Lodge became quite strong. Indeed, as noted in the above description of the Lodge, the community was successful in its attempts to ensure that the facility was not closed down. It was not until after the Provincial government transferred administrative authority to a local Board of Directors that Skeenaview Lodge began to develop relationships with other community organizations. The transfer of authority made it possible to orient the use of certain existing resources towards the local scene. The use of the Lodge's dietary facilities for the support of a Meals-on-Wheels programme is the best example from the research data of the use of resources (facilities and dietary department staff) for this purpose. Certainly the advent of this programme enhanced relationships between Skeenaview and the local Community Resources Board.

However, the role of physical resources in enhancing the new "outward" looking orientation of the Lodge is not seen to be as important to the development of organizational relationships as is the role of human resources. The organizational mandate for Skeenaview was not to bestow funds or facilities. Rather, it was the treatment and care of the mentally ill. Within those terms of reference it was the activity of the Board and administration of the Lodge which became the prime factor in developing interchange with local organizations. The technical or administrative
organization of the Lodge was oriented towards this goal. Hence it was the representation of people identified with the Lodge which served to develop the relationships. In this sense then the skills, knowledge, and experience of the administrative personnel combined with the technical organization of the Lodge are the resources which registered the greatest impact in developing interorganizational relationships at the local level. Examples of this are the role played by the Skeenaview Board and society in assisting to establish the Osborne Guest Home. As well, the relationships between Skeenaview and the Community Resources Board was evidenced by the fact that the Chairman of the Community Resources Board was the Administrator of Skeenaview.

The Terrace Association for the Mentally Retarded is an organization which relied heavily upon the abilities and initiative of its own membership in establishing interorganizational relationships. In order to pursue its organizational objectives the Association was obliged to solicit other organizations for needed resources such as funding, organizational advice, and professional staff. The activities of the Association as described previously are analogous to that of a middle man. While in the past, the Association has not provided nor directly funded, client services, it has identified sources of needed resources and facilitated the transfer of these resources to agencies which
do provide client services. In this role two basic types of relationships are established. The first is with organizations which are resource providers. The second is with organizations which are designated as recipients of the solicited resources or on whose behalf the Association is acting.

As the Association membership gained experience in their activities, the success of projects they undertook to support was greatly enhanced. Witness the plight of the Three Rivers Workshop, which was their first venture as compared to the more recent success of the Alice Olsen Home. As well as having gained experience, there was enlarged organizational environment involved in that more types of organizations were solicited in establishing Alice Olsen Home. The opportunity for pooling collective resources of several organizations was recognized in that venture. The point to be made here is that experience in and knowledge of the system of funding community mental health projects became an important asset to the Association. It rarely, if ever, controlled the disbursement of resources such as money but was able to use the resources of expertise and experience in order to achieve its goals through other organizations.

The analysis of the Kitimat Child Development Centre's interorganizational relationships within a resource context again provides some unique opportunities to show the effect of resources upon these relationships.
The Child Development Centre relied heavily upon non-local agencies for support and assistance in both its initial start-up period and in its subsequent operations. Funding, organizational advice, and most professional staff had all been provided directly through the offices of the British Columbia Cerebral Palsy Association. These resources have continued to be provided in varying amounts throughout the existence of the Centre. The reliance upon the financial and organizational resources of the B.C. Cerebral Palsy Association is very high. Without this kind of support the Centre would not be able to function.

In spite of this there was no mention by the Centre's representatives of any undue imposition of policy upon the Centre. The funding was provided for programming within certain parameters but once these were met the Centre and its Board could and did exercise considerable independence in its operations.

There was some pooling of resources as an attempt to stretch the programme budget of the Centre. Both the Terrace and Kitimat Child Development Centres cooperated in hiring shared professional staff. However, beyond this development there were no other formal relationships between the two. It was purely an economic arrangement that was designed to enhance treatment programmes in both facilities. It is seen here that relationships spawned by resource related concerns are not necessarily limiting upon any organization nor do these relationships neces-
sarily proceed beyond the narrowly defined terms of resource exchange. However, these points will be brought to light in the subsequent section of the chapter dealing with organizational autonomy.

**Power**

Organizational power is a phenomenon which has several consequences for Level II interorganizational relationships.

In consideration of the definitions of power presented earlier in this study, the Osborne Guest Home does not appear to be a powerful organization within its organizational environment. It controlled few resources required by other organizations, had no legislative authority, and was only just beginning to develop its credibility with other organizations. In a sense its available power base had been eroded by the presence of so diverse a group on its admissions committee. With so many organizations represented on that committee the administration of the Home had little control even over who was to be admitted as clients. The fact that the Home was a new entity in the local community mental health sphere also contributed to a relative lack of power.

The Skeenaview Lodge was an organization which, in contrast to the Osborne Guest Home, was seen by the writer as an organization invested with some power. While it was not an organiza-
tion in control of economic resources to be bestowed upon other organizations it was the human resources, discussed in the previous section which were identified as the main sources of power. The first point to consider in that view, was the power over the local community which the organization probably did not acknowledge that it had. In this one context the organization, as an industry, did possess economic power within the community. It is evident from the data collected on this organization that the power was only evidenced by the community responses to the attempt by the Provincial government to close down the institution.

In this sense, however, power does not seem to be reasonably ascribed to the Lodge. There had been no attempt on behalf of the organization to utilize its economic strength in the community. However, when the administrative authority for the Lodge was placed in the hands of the local Board of Directors it can be argued that power was then given to the organization to effect its own interorganizational relationships. Indeed, its efforts, or that of its Board, were evidenced in the creation of the Osborne Guest Home and the support given to the Meals-on-Wheels programme of the Community Resources Board. The power that was most noticeable, however, was that which was carried by the Administrator of the Lodge. This individual was a charismatic and dynamic person who served as the Board Chairman of the Community Resources Board. While the power that he had was not seen to be
utilized in his role as administrator of the Lodge his influence on the activities of the Community Resources Board served to highlight the presence of the Lodge in the community and served to enhance the goal of the Lodge to become more prominent as a local community oriented organization. Thus, the referrent power ascribed to the leader of the organization by members of other organizations would, to some extent at least, be transposed to the Skeenaview Lodge.

The power of the Terrace Association for the Mentally Retarded was largely a function of its association with other organizations which controlled economic resources and/or which possessed legislated authority. The Association itself controlled very few of these resources but did however, succeed in obtaining resources through its alliances with Provincial voluntary and governmental organizations. Indeed, once the negotiations for support of the Alice Olsen Home had been completed the Association was not endowed with either funding control or administrative control over the operations of the facility.

The Association did control access to funds, at least locally, from sources such as the British Columbia Association for the Mentally Retarded. But even in this light, the power of the Association itself was quite limited. Any authority it possessed was vicarious in nature and direct involvement with local organizations the Association helped to establish usually did not
result in any long lived administrative authority being held by the Association. Further to this there did not seem to be any leadership role with the Association which would permit an individual member to be identified as the representative of the Association. Hence, there was no power attributed to the Association at the local level through the strengths of its leadership.

The interorganizational relationships of the Kitimat Child Development Centre were not seen to be affected significantly by the presence or absence of power held by that organization. In actuality the Centre controlled few economic resources except those which were for its own purposes. At the local level, the organizational relationships it was engaged in were not seen to be at all influenced by the presence or absence of control of resources. The Centre was maintained through the financial assistance it received from the British Columbia Cerebral Palsy Association. As was the case with the Terrace Association for the Mentally Retarded the relationship with the funding organization was not seen to be influenced by the fact that there was heavy financial dependence. The power of the funding agency did not appear to extend to the level of influencing the programming or operational policy of the Centre.
Organizational Autonomy

For each of the four organizations chosen for analysis in this section of the study, organizational autonomy is an important factor.

The Osborne Guest Home was an autonomous entity in terms of administration of most of its day-to-day operations. None of the organizations which assisted in establishing the Home maintained any kind of official jurisdiction over the activities of the Home. However, there was one important factor which served to undermine the autonomy of the Home to some degree. The fact that so many organizations had representation on the admissions committee of the Home has been mentioned previously as an erosion of the power of the Home. It is suggested as well that this represents a diminution of the Home's autonomy. In this sense, the notion of a federation of organizations as outlined by Warren (1967) would seem to apply.

While the authority for ratification of decisions regarding the admission of clients lies officially with the Home, the other organizations do act together to influence the decisions that are made.

In the case of the Skeenaview Lodge there was a notable historical point at which a degree of organizational autonomy was confined upon the organization by Provincial authority. By es-
establishing a local Board with administrative responsibility for the operation of the Lodge, the Provincial government may not have relinquished much of its control over the Lodge. By maintaining ultimate control over the economic resources of the Lodge the move to decentralization of authority evidenced by the creation of the Board may only have provided a degree of local autonomy for the Board. Indeed, the fact that the Board saw the enhancement of community relations as a new and important organizational goal may be evidence that this was the only real latitude afforded to the new Board. To oversimplify, it may have been the only flexibility the decentralization allowed. Clearly, at the local level the Skeenaview Lodge could have remained untouched by the local organizational environment. There was no evidence that Skeenaview depended upon any of the local community mental health organizations for anything. In spite of the existence of the Board the Lodge could have remained aloof. However, the values of the local group were such that this should not be the case. The choice was made to extend the resources at the Lodge's disposal to the community.

The Terrace Association for the Mentally Retarded was described earlier as being an organization with a small sphere of organizational activity. Partly as a function of this circumstance the autonomy of the Association seems to be of only periodic significance in its organizational relationships. As a
voluntary organization which was not engaged in direct client services there were no continuous, daily operations to be performed. Consequently the reliance of the organization upon resources seemed to be project oriented. That is, it was only when the Association identified specific projects that fund raising became important. Although there was a linkage between the Terrace organization and the British Columbia Association for the Mentally Retarded, this did not compromise the autonomy of the Terrace group. Indeed, it appeared that T.A.M.R. was able to freely establish relationships with any organization it chose. The alliances which developed did not, as previously noted, create any jurisdictional responsibilities. The Association was almost able to "free-lance" in its activities as it retained little or no administrative control over the projects it helped to launch.

The organizational autonomy of the Kitimat Child Development Centre, unlike the Terrace Association for the Mentally Retarded, was influenced to a degree by more formal and long-lived associations with groups and agencies which constituted its organizational environment. Part of the difference is seen to be due to the fact that there were regular organizational commitments in the provision of direct client services. In accepting these kinds of commitments and in becoming dependent upon resources of other organizations, a portion of the autonomy of the Centre was
forfeited. The sharing of professional staff with other organiza-
tions is not offered here as a surrender of autonomy except
that it might restrict the scheduling of services of that staff
member. Nor did the link between the British Columbia Cerebral
Palsy Association and the Kitimat Centre seem to impose re-
strictions upon the programming of the Centre. Although the
B.C.C.P.A. provided a large portion of the funding for the
Centre, the independence of the Centre was not compromised
through and legislated on contractual agreements. Rather the
autonomy of the Centre operations was potentially threatened by
the expectation regarding future relationships with other local
community mental health organizations. The clue to this pos-
sibility lies in the hope expressed by the administration of the
Centre that a continuum of treatment programmes might be estab-
lished and that the programmes provided by the Kitimat Associa-
tion for the Mentally Retarded and the Kitimat School District
No. 80 would complement each other. The expectation then, as
noted previously, was that a child might progress through the
programmes offered by different organizational jurisdictions. It
may be that this development would result in negotiated com-
promise by all organizations concerned and that the programming
of each be limited. By engaging in these types of formal re-
lationships an individual organization's programming flexibility
could be sacrificed.
Domain Consensus

Domain consensus is a dimension which affected both the Osborne Guest Home and the Skeenaview Lodge in similar ways. Both of these organizations had clear organizational roles which were defined by contractual agreement in the case of the Osborne Guest Home (between the Home and the Department of Human Resources) and by legislated authority in the case of the Skeenaview Lodge. As well, neither organization was seen to overlap the jurisdictions of other organizations in the study area. These factors were likely important determinants in helping these organizations maintain positive relationships with other organizations. Certainly, the fact that so many organizations had input into the Osborne Guest Home should have eliminated any confusion over the role of that organization. The Skeenaview Lodge, however, because of its recently acquired autonomy and its stated goal of expanding its activities into the community could potentially intrude into established domains of other organizations. At the time of the study, however, there did not seem to be any evidence of this happening. Most of the efforts in the Lodge's expansion activity had been viewed by other organizations as filling gaps in current community services.

The Terrace Association for the Mentally Retarded did not seem to have clearly defined its organizational domain. It was
generally intended to advance the quality and quantity of services to the mentally retarded and to assist parents of mentally retarded children to adjust to the problems of raising those children. However, there had been an almost ad hoc approach in the kinds of projects the Association had supported. The creation of the Three Rivers Workshop, the support provided to help establish the Alice Olsen Home, and the donation of a bus to a training school located in Smithers are all projects generally related to the provision of services to the mentally retarded. However, there were no specific agreements in existence which defined in either legal or contractual terms what the role of the Association was to be. Instead, there was an implicit kind of understanding that the Association should or could be doing the kind of things it had been doing. The fact that funding for the Alice Olsen Home had been gathered largely through the efforts of the Association can be construed as evidence that this project was within the domain of the Association, at least insofar as the organizations and people providing the funds were concerned. The failure of the Association to secure long-term financing for the Three Rivers Workshop may similarly be construed as evidence that that project was not seen by funding organizations as justifying ongoing support. That being the case, the question arises as to whether that project was or should have been within the domain of the Association. No answer is offered here. The
observation is made that success and/or reasonableness of a project cannot be measured only in economic terms nor is it an indication of an organization transgressing its organizational jurisdictions.

The Kitimat Child Development Centre was another organization which lacked contractual and/or legal definition of its domain. The treatment programmes it offered to its clients were provided according to the abilities of the professional staff. On that basis then there was an understanding about the kinds of programmes the Centre would offer. In the absence of a like treatment organization in Kitimat there was little chance for the programmes to be questioned by other organizations.

The role of the Kitimat School District No. 80 in providing special education classes was not questioned by the officials of the Centre. Criticism was based on content of the programme not on the prerogative of the School District to provide it.

Interorganizational Coordination

The fifth dimension to be considered in analysing Level II interorganizational relationships is that of coordination between organizations.

The Osborne Guest Home served as an example of the ability of organizations to coordinate their activities to their mutual
benefit. This statement applies not only to the establishing of the Home but the way in which it continued to operate. While the professional staff of the Home developed their own treatment styles, much of the treatment of individuals staying at the Home was based on the prior input of other mental health professionals in treating these people. That is, individual treatment programmes were developed in consultation with professionals from other organizations. Another form of coordination is again evidenced by the composition of the Home's admission committee. The Home, in a very real way, became an instrument which brought together representatives of several local community mental health organizations. The form thus provided permitted a coordinated use of the facilities of Osborne Guest Home.

The Skeenaview Lodge was another organization which served as a coordinating entity. Much of its treatment programmes were provided independently of the local community mental health organizations, therefore there was little opportunity to coordinate their efforts at providing care. However, administrative staff of the Lodge did seem to be able to offer assistance in local attempts to coordinate services. The support for and representation on the Community Resources Board was seen as a strong commitment to the notion of coordinated services in Terrace. Similarly, the activity of the Lodge's Board which
assisted the Osborne Guest Home in becoming established called for coordinated efforts of Skeenaview's Board and local mental health organizations.

The Terrace Association for the Mentally Retarded had a positive orientation to provision of coordinated mental health facilities. This was most evident in its relationship with the Alice Olsen Home. It was the coordinated activities of the Association with the Department of Human Resources which succeeded in establishing the Alice Olsen Home. However, in contrast to this coordinated effort, establishment of the Three Rivers Workshop was virtually a unilateral effort by the Association. Insufficient attention by the Association to the long-term plans for the Workshop was due to lack of inexperience. Hindsight illustrated that this long-term planning was essential. This lesson was not lost on the Association as the success of the Alice Olsen Home shows.

The administration of the Kitimat Child Development Centre had a strong orientation to the notion of coordinated services. Although there was little evidence at the time of the study to support this claim the sharing of professional staff with the Terrace Child Development Centre was clearly an attempt to maximize use of scarce resources. In addition, the reference to the idea of a continuing of services between different treatment agencies such as the Centre and the Kitimat School District is
evidence of the value the administrative staff of the Centre placed on the efficient use of resources. Speculation arises in reference to the criticism of the quality of the programme currently provided by the School District as to the actual outcome of any attempts to coordinate services. The prospect of conflict in this effort is a possibility although this should not necessarily mean the failure of any coordinated efforts.
CHAPTER VI

INTERORGANIZATIONAL RELATIONSHIPS - LEVEL III

Conceptually, analysis of interorganizational relationships from a Level III or suprasystem perspective is the greatest challenge of this study. No longer is the individual organization the focus of attention. Rather, the analysis in this chapter centres upon the aggregate of community mental health organizations in Terrace and Kitimat viewed in the context of a single entity. This multi-organizational unit is composed of seventeen organizations which were identified as constituents of the community mental health interorganizational field within the two centres.

The difficulty in description and analysis of interorganizational relationships at this level is that the individual organizations fluctuate in the degree to which they participate in the activities of the field. While the membership of the field can easily be determined, the nature of the interactions between and among the member organizations is dynamic. The structure of the field is such that there is no centralized decision-making
authority. While agreements can be negotiated by groups of organizations to proceed in specific directions there remains a considerable degree of unilateral decision-making authority within the field. A description of the structure therefore will need to be assembled through an analysis of the processes that were evidenced in the research data. These processes are the relationships between and/or among organizations which were viewed by the writer as being influenced by various factors and characteristics of the organizational environment.

Example Number One

The first multi-organizational relationship that is to be discussed involved an attempt to establish in Terrace an inter-organizational committee to address problems regarding children with learning difficulties. The committee was formed by the incentives of a number of professionals from various organizations who felt that there were inadequate facilities in Terrace to provide adequate treatment for emotionally disturbed children. The organizations represented on the committee were the Skeena Mental Health Centre, the Department of Human Resources, the Local Board of Health, and School District No. 88. As well, two or three physicians were regularly in attendance at committee meetings. The composition of this committee shows that there was a consen-
sus among at least these organizations in the belief that there were gaps in services being provided to a specific clientele. It also shows that there was a willingness on behalf of the participating representatives to try to come to terms with this identified lacuna.

It is apparent that the organizations had all been identified by each other as having at least a marginal concern with the identification and treatment of emotionally disturbed children. This can be assumed by virtue of their participation on the committee.

It is known, as well, that the committee was intended to be a forum for communicating among the participating organizations. Until the committee was formed there had been no official and/or regular means of exchanging information regarding the activities of these organizations vis-a-vis the needs of emotionally disturbed children in the community. The committee, therefore, was formed partly in response to that communications gap.

The efforts of the committee had not borne much fruit. This may have been due in part to the short period of time which had elapsed since it first met. The group had only been meeting for a period of six months at the time this study was done. However, it was said by one of the participants in the group that another reason little progress had been realized was that the level of participation by some organizations was not very intense. By
this it was meant that some representatives who attended the committee meetings contributed very little. This may be attributable to several factors but two important concerns become obvious. Did all the organizations represented actually have anything to contribute or did they participate on the committee only by virtue of their activity in the community mental health field? Secondly, did the representatives to the committee lack authority and/or knowledge to make a contribution to the meetings and commitment to the other organizations? These questions cannot be answered in this study. However, in the absence of objective data, they do stimulate further questioning. Do organizations participate in such ventures because they are coerced to do so by other organizations which expect them to become involved in that kind of activity? Was there in fact a gap in service which required multi-organizational input for resolution? Perhaps the committee was really trying to identify the true nature of inadequacies which were believed to exist. If that had been the focus of their activities then the outcome of the committee's effort may not have been viewed so pessimistically. Unfortunately, the committee was not subject to any interviews conducted in the course of this study and the above queries must all be left unanswered. Nevertheless, the above example does serve to illustrate that there are a number of possible reasons for organizations to enter into relationships with others and that the
organizational environment may serve to influence these various motivations.

**Example Number Two**

The second instance of interorganizational relationships being influenced by the interorganizational field or suprasystem of community mental health organizations is, like the previous example, related to the creation of new structures within the field. On at least three occasions local organizations took the initiative in establishing new community mental health programmes and facilities.

On two of these occasions a single organization, the Terrace Association for the Mentally Retarded (T.A.M.R.), was the principal actor at the local level. In its first venture this voluntary organization acted independently of other local agencies in securing funding and professional advice for the establishment of the Three Rivers Workshop. T.A.M.R. members identified a local need, located funding from an external source, and established the workshop, apparently with minimal consultation with other community bodies. There was no evidence presented that other community organizations had been involved in this venture. The problems and criticisms which later beset the operations of the Three Rivers Workshop may have been at least partially due to the
lack of any prior consultation with other local mental health organizations. However, the nature of the field was such that this kind of action could take place without extensive prior negotiations with other community organizations. Even if other local agencies had actually been contacted in regard to the planning of the workshop, it may be assumed that little opposition was raised. However, based on information received from T.A.M.R. officials, it is more likely that this prior consultation did not take place.

In the second T.A.M.R. sponsored project, the creation of the Alice Olsen Home, there was substantially more interorganizational consultation. This may have been due to the fact that T.A.M.R. had gained more experience and knowledge in the ways in which such projects should be approached. Certainly, the representatives of T.A.M.R. who spoke about this project indicated that they were far wiser as a result of their Three Rivers experience. In any case, organizations such as the Department of Human Resources and the British Columbia Association for the Mentally Retarded were highly involved in the Alice Olsen Home project. The success of such a project required the consolidated efforts of more than one organization and it is clear that the necessary operational funding which was provided by the Department of Human Resources was a resource which T.A.M.R. now recognized as being essential for such facilities. It is interesting to
note, however, that input to planning for the Alice Olsen Home from the local level, was still not very important for the planning process. T.A.M.R. was able to meet its goals through the services, authority, and resources of agencies which were based at the provincial rather than the local level. The question arises as to how new services such as the Alice Olsen Home become integrated with existing services such as the Jack Cook School.

It would seem, without having further information, that the facilities such as Three Rivers Workshop and the Alice Olsen Home are examples of how the local organizational environment is affected by plans of an ad hoc, incremental nature. This observation is not made in any judgemental sense. However, the impact of the one ill funded and ill operated project, the Three Rivers Workshop, upon the community could stand as evidence against such a planning process. Contrasted with the success of the Alice Olsen Home, which had joint funding and support from the Department of Human Resources, one of the major actors in the local community mental health environment, it is obvious where the advantages lie.

The third facility which was established through the efforts of local organizations was the Osborne Guest Home. As was the case with the Alice Olsen Home, operational funding was secured from the Department of Human Resources. The distinction in the way the Osborne Guest Home was established lies in the magnitude
of involvement by local community mental health organizations. Stating it very simply, more organizations identified the need for an adult residential facility and thus more organizations had input into its planning. It is clear as well that more local organizations continue to relate to the Osborne Guest Home than to the Alice Olsen Home.

Although extensive reference to the Osborne Guest Home was made previously in this study in the context of Level II analysis of interorganizational relationships there are important consequences for analysis at the suprasystem level. The fact that local organizations had had such a unified approach in establishing the Osborne Guest Home serves witness to the existence of an atmosphere conducive to coordinated efforts of community mental health organizations. It was possible for those organizations to act together in their own mutual interests.

Example Number Three

Perhaps one of the most interesting opportunities to view interorganizational relationships from the suprasystem viewpoint is presented by a review of the Terrace and District Community Resources Board. The word 'interesting' is used because in theory the Community Resources Board was intended to be a coordinating body but in fact had not been able to effect very signif-
icant responses from existing community mental health organizations.

The Terrace and District Community Resources Board and others like it throughout the province, were the product of provincial legislation which was introduced in 1974 to help communities throughout British Columbia to coordinate efforts in providing local social services. Furthermore, the legislation was an attempt by the provincial government to decentralize the provincial authority in social service areas and to place responsibility for these services in the hands of local communities. While the mandate for these local boards was broadly based they were seen as organizations which could become vitally concerned with community mental health matters.

In Terrace, for instance, the Community Resources Board had members on its Board of Directors from the Skeena Mental Health Centre, the Skeenaview Lodge, and two (of the local staff from the) Department of Human Resources. However, the extent to which the Board had actually dealt with specific mental health issues seemed to relate less to coordination of existing services than to provision of financial support. Three Rivers Workshop, the Child Development Centre, and the Crisis Line operated by the Board had all been cited as organizations which would receive financial support from the Board if and when the authority to collect and disperse this money was given to the Board. However,
the intent here is not to enumerate so much what the Board had actually accomplished in its three years of existence but more to examine how its presence as a coordinating body had been received by community mental health organizations. The impact, it appears, was small. The Board had virtually no authority at the time the study was conducted and had no resources at its disposal that could have been used to direct or assist other organizations. It appeared to be a 'paper tiger' and until provincial authority was actually turned over to the Board many of the aspirations of the Board would remain unfulfilled.

It may be, however, that the existance of the Board managed to afford a further opportunity for various representatives of community mental health organizations to at least meet with one another on a regular basis but the significance of that opportunity can not be addressed here. It appeared to the writer that the various organizations continued to function independently of one another and that the various kinds of resource exchanges they may have had with one another was not altered or influenced by the presence of the Community Resources Board.
Resources

Resources, their relative accessibility, and their sources are an important concept to consider in analysing relationships among organizations in a specified interorganizational field.

In any network of organizations resources may be expected to form a basis for exchange amongst members of the network. In the example of the organizations which formed a committee to address problems associated with emotionally disturbed children, the resources involved were non-monetary. Information was the key element that was to be exchanged. This information exchange dealt with the ways in which the organizations were dealing with specific clients who were being treated by more than one organization. As well, information was exchanged about client referrals which the organizations were making to one another. Although these elements of exchange are identifiable as resources, the presence or absence of this particular exchange may not have had important consequences for all participants. This is an assumption based on the claim made by one committee member that not all organizations were as vigorous in their participation as could have been expected. Perhaps an overabundance of other
referrals and clients served to reduce the enthusiasm over prospects for increasing already oversubscribed case loads.

In a monetary context now, the examples of how the Terrace Association for the Mentally Retarded acquired resources for certain projects can be seen to have a relationship to the way organizations interact at the local level.

In both examples where T.A.M.R. sought funding, the primary sources of that funding were located outside the local organizational environment. The reason for this is that there were limits to the amounts of money that could be secured from local sources. In T.A.M.R.'s experience most, if not all, of the locally raised financing came as charitable donations from the citizens, service clubs, and the business community. Local community mental health organizations could not be expected to assume the operational liabilities for a new facility. The point to be made here is simply that the composition of the local organizational environment did not include organizations with funding power to support other local agencies. Thus virtually every community mental health organization in Terrace and in Kitimat was dependent upon funding flowing into the region. Typically this funding was provided by the provincial government or a provincial voluntary association which generated large amounts of revenue through annual charitable campaigns.
In such an environment it does not seem unusual that an organization needing finances, such as T.A.M.R. did, would proceed directly to these external funding sources without prior consultation with other local organizations. The model for securing funding precluded any local involvement. It was only after the external sources had been solicited and funding was denied that the members of the local organizational network were sought out to help remedy the plight of the Three Rivers Workshop.

However, there does seem to be evidence of another pattern of interaction at the local level among organizations seeking funding for new facilities. This pattern is typified by local organizations banding together to orchestrate a consolidated approach to external funding bodies. This method seems to have had more success than the unitary approach and was used in the establishment of both the Alice Olsen Home and the Osborne Guest Home. While the external agency (the Department of Human Resources) was still the ultimate source of funding, local agencies were able to make and keep limited financial commitments at the local level to obtain the initial capital required for both these projects. Clearly, there were advantages gained by planning these kinds of ventures with other agencies and by having had prior discussion with external bodies that provide operational funding.
The notion of having a local body in authority to coordinate these kinds of projects and to control the disbursement of financial resources at the local level was the anticipated role of the Community Resource Boards. However, with neither authority nor resources, the impact of the Boards in Kitimat and Terrace was limited. In effect the Boards were superimposed upon the social services organizational network and gave the tantalizing promise of local control over resources. In Terrace the promise was sufficient to draw the resource hungry organizations, such as Three Rivers Workshop, into the fold but without actually being able to contribute spendable dollars the promise gave way to some disillusionment. The network of community mental health organizations was essentially unaltered by the presence of the Board. Resources were still largely controlled outside the region and all organizations depended upon linkages outside the immediate environment for these resources.

Power

From the suprasystems level of analysis of interorganizational relationships, power is a variable which proves difficult to identify within the locale of the specific interorganizational field.

In a resources context it is apparent that most of the power
that affected interorganizational relationships at the local level was in the hands of an external authority. This is particularly the case in regard to financial resources. The absence of economic power at the local level may have contributed to the relative harmony or at least lack of hostility among the community mental health care organizations. Each of the agencies relied independently upon external sources of funding. This consequently diminished the possibility of any local organization being in a position of dominance over another, at least from an economic point of view. The one exception in Terrace may be seen in the relationships of various organizations to the Community Resources Board. As stated previously, some organizations had gone to the Board to seek financial support if and when it was to be made available. Even the promise of funding was sufficient to establish a power based relationship between the Board and those dependent organizations.

There may have been some evidence of certain organizations possessing referant power at the local level. In Terrace there were three organizations which were frequently cited as being formally involved with a variety of organizations for a variety of purposes. Specifically, the Skeena Mental Health Centre had representatives involved with the Community Resources Board, the interagency committee on emotionally disturbed children, and the founding of the Osborne Guest Home. The Department of Human Re-
sources, District #7, had been similarly involved but in addition had developed ongoing relationships with the Terrace Association for the Mentally Retarded, the School Boards in both Kitimat and Terrace, and likely several other community mental health organizations located outside of those two communities. The third organization which seemed to be omnipresent in community mental health activities was the Skeenaview Lodge which had participated in the creation of the Osborne Guest Home and was involved in the Community Resources Board. The extent of the interrelationships which these three organizations participated in may be evidence to support the claim that they were in positions of power in the region. While it is difficult to assess the validity of the claim it is interesting to note that these three organizations were operated by the provincial government. Because of the wide mandate attached to the roles of the Department of Human Resources district offices and the Skeena Mental Health Centre they may have assumed or been accorded a high profile in the local mental health care scene.

As regards the frequency of the involvement of the Skeenaview Lodge the charismatic leadership of the administrator was likely the most important factor.
Organizational Autonomy

Organizational autonomy is subject to several variables but the significance of these variables in analyzing interorganizational relationships from a suprasystems viewpoint seem to vary somewhat.

Within the confines of the interorganizational field of Kitimat and Terrace most organizations, as has already been discussed, are financially independent of one another. In this respect they are autonomous. Organizations are not obliged to confer with others prior to taking decisions that are related to financial matters. However, the resources that the funding secured such as manpower, technology, and facilities for delivering services were seen to be more frequently interrelated among organizations and consequently these kinds of resources are more central to the discussion of organizational autonomy.

The majority of community mental health organizations in Kitimat and Terrace were, in fact, quite active in their relationships with other community mental health organizations. Organizations in these interrelationships were seen to be surrendering various degrees of their autonomy depending upon the frequency and duration of the interrelationships, the nature of the resources being exchanged, and the long-term objectives of the exchange.
In the examples provided above none of the organizations participating in the interagency committee on problems of emotionally disturbed children were seen to have forsaken much of their autonomy by participating in the committee proceedings. While the committee met regularly and could possibly become a long-lived forum for the participants there was little commitment by the organizations to exchange any resources except for information. Nor did it seem that the committee's mandate would develop into anything more than that. The objectives of the committee were fairly general. Decisions reached about specific treatment programmes for specific clients had not been reported to have had anything but superficial impact on the ways in which the participating organizations functioned in regard to emotionally disturbed children.

Similarly, in the case of the Osborne Guest Home where a consortium of organizations acted together to establish the Home the long-term effects of the interaction upon individual organizational autonomy appeared to be negligible. As discussed in a previous chapter the only organization which seemed to forfeit its autonomy was the Osborne Guest Home which, because it was a new organization, had been established with a lesser degree of autonomy than its organizational peers. The same can be said of the Alice Olsen Home which, after its creation, was highly dependent upon the resources of both the Department of Human
Resources, the Jack Cook School, and the Terrace Association for the Mentally Retarded. The coalitions of organizations which helped to establish these two residential facilities were able to retract their involvement with one another and to reestablish their former levels of autonomy vis-a-vis the other community mental health organizations.

The Community Resources Boards were the closest approximations of the federative approach to community mental health. Even here, however, the participating organizations were not required to compromise their autonomy to any great extent. In fact the observations made during the course of this study would seem to indicate that in Terrace there were two levels of organizational involvement with the Board. The first level was composed of established organizations whose representatives served in an advisory or directing role on the Board. These organizations were the autonomous groups. The second level of organizations were those which had turned to the Board for assistance. In making requests for financial aid those organizations did surrender their autonomy because funding was to be forthcoming according to the judgement of the Board members. In this context, there was a vertical relationship established at the local level between the Board and the organizations which it sponsored. This vertical relationship was identical to that which existed between the more affluent local organizations and their sources of
revenue and authority. The Community Resource Board did manage (or would have, had it had resources to disburse locally) to bring decision-making down to the local level. It seems ironic that the local decision-makers were largely those people who were employed in organizations whose funding and ultimate decision-making authority came from a remote source.

Domain Consensus

Within the interorganizational field set out for description and analysis in this study the concept of domain consensus is one which is particularly important to analyse. This is so because interorganizational relationships are formed on the basis of one organization's role vis-a-vis another organization's role.

From a broad perspective it was apparent that the community mental health organizations which were identified in the course of this study have all established their own organizational domains. These domains may or may not be clearly and rigidly defined. In this context it is necessary to point out that there may not be mutual agreement amongst these organizations as to the appropriateness of each others role and scope of activities. Obviously there were organizations which had unique jurisdictions. The Skeenaview Lodge, the Alice Olsen Home, the Osborne Guest Home, and the Child Development Centres in Kitimat and
Terrace had all laid claim to unique and separate mandates within the local interorganizational fields. That is, there were no other organizations which performed similar roles.

However, several organizations were seen to have overlapping jurisdictions. The fact that an organizational domain does or does not overlap with that of another does not necessarily determine the nature of interrelationships between or among the organizations. Taking again the example of the interagency committee on problems of emotionally disturbed children, it is clear that the participating organizations had either developed or were believed to have developed some expertise or involvement in the affairs of emotionally disturbed children. Participation on that committee was based on the acknowledged or accepted involvement of the organizations in that treatment area. It should be noted that there was no apparent attempt on behalf of the participating organizations to limit the activities of each other in that area. Rather coordination of efforts or at the very least exchange of information amongst the various jurisdictions was the goal. In this respect there may have been a subtle limiting effect in evidence. Coordination of activities may require that domains be readjusted to accommodate the coordinating function. No data was generated which could confirm this hypothesis. It can be assumed that the organizations did manage to agree on their respective roles or at least to accommodate each other in those roles.
One area which can not be addressed in this study but which is germane to the notion of domain consensus is the degree of difficulty other, non-participating, organizations had in differentiating between the various organizational roles. Perhaps even more importantly, could the clients and potential clients differentiate organizations clearly enough to determine with which one they were to deal?

Another aspect of domain consensus which is important at the third level of analysis in this study pertains to resources. In the example of the Community Resources Boards there were several organizations in Terrace which were anxious to receive funding support from the Terrace and District Community Resources Board. Because of the representation on the Board by a number of other community mental health organizations and because of the decision-making authority of the Board in allocating resources, there was a true consensus among the members of the Board as to the appropriateness of the domains of organizations seeking funding. In this process there was a formal discussion regarding each organization's request for assistance to gain agreement as to the degree of support to be given and for which purposes the resources could be used. There does not seem to have been such a forum for defining the jurisdictions of other community mental health organizations. While there did not appear to be any major concerns voiced as to the appropriateness or inappropriateness of
various organizational roles neither did it appear that at the local level there had been any formal discussion and agreement on roles. The organizations seemed to be able to arrive at agreements regarding their domains by interpreting their legislated or acknowledged mandates, in relationship to local needs and available resources. In a restricted geographical setting, this kind of negotiation may have been more easily accomplished than in an urban centre with a myriad of organizations constituting an interorganizational field.

Interorganizational Coordination

Following from the discussion immediately preceding concerning domain consensus, the phenomenon of interorganizational coordination becomes particularly relevant to analysis at the suprasystems level. The community mental health field is an environment which has been criticized for its lack of achievement in coordinating activities. Indeed when looking at the mosaic of community mental health organizations in Terrace and Kitimat, there is ample opportunity for services to become disjointed and discontinuous: there are provincial organizations operated by separate governmental departments; there are voluntary associations which have specific fields of interest and which receive varying degrees of support from a variety of provincial associ-
ations; there are regional and municipal authorities which also have jurisdictions related to community mental health; there are private physicians; there are ad hoc citizen groups which have no sponsor or legislated authority at all. In the weave of this organizational tapestry is the consumer, the client with some sort of psychological impairment.

The rationale behind the arguments for and attempts to coordinate services is a strong one. Within the context of the interorganizational field of Terrace and Kitimat there was evidence that efforts at coordination had affected interorganizational relationships on different occasions, witness the frequently mentioned interagency committee. However, there did not seem to be any formal process that had been established to achieve a continuity in coordinative efforts. The Community Resources Boards were the only exception. The Boards, however, had the potential to coordinate efforts of only a limited number of organizations. The composition of the board memberships may have been multi-organizational in format but there was no authority over any organizations except those which were designated to receive funding from the Board.

Overall the impression was gained that conflict between and among organizations was minimal. This was not a measure of the level of coordination. Indeed, save for the ad hoc, project inspired examples given above there was little evidence of attempts
at interorganizational coordination on anything but a Level II basis. There was evidence coordination between organizations was on an ongoing basis but little to suggest substantive coordinative efforts among organizations.
CHAPTER VII

SUMMARY AND CONCLUSIONS

In stating the purpose of this study three main objectives were established. The first, "to discuss and analyse factors which influence relationships between and among" community mental health care organizations in Kitimat and Terrace has been achieved in Chapters IV, V, and VI. It is the intent here to draw upon these analyses in order to address the two subsequent but more substantive purposes of the study. These are specifically, "to discuss the significance of the systems theory concepts in explaining problems affecting subject organizations" and "to generalize this discussion to other related fields of social policy and planning."

Systems Theory Concepts As Applied To This Study

In assessing the significance of systems theory concepts for purposes of this study the following discussion is divided into two topic areas. The first addresses the three levels used to
categorize the nature of interorganizational relationships and
the second focuses on the five dimensions used to develop the
analysis at those levels.

Three Levels of Interorganizational Relationships

The main intention of analysing interorganizational re­
lationships from intra, inter, and supraorganizational perspec­
tives was to determine the relative strengths and weaknesses of
each of the approaches in describing the interactions of the
community mental health care organizations in Kitimat and Ter­
race. In this respect several observations are in order.

Firstly, it can be concluded that at each level of analysis
it was possible to analyse information regarding the ways in
which individual organizations interacted with other organiza­
tions. There were, however, varying degrees of success in this
regard. By definition, the third level of analysis was not
intended to address concerns of individual organizations. As a
consequence, individual organizational interactions were seen by
the writer to be most appropriately analysed from the Level I and
Level II perspectives. Nevertheless, this statement should not
diminish the importance of analysis at Level III even for indi­
vidual organizations. The fact that a broad spectrum analysis
can provide an organization with a sense of place and role within
an overall interorganizational field should be an incentive for that individual organization to document and evaluate factors which influence its position in its organizational environment.

Organizational problems and/or areas of concern were clearly evidenced in this present research to stem from internal and external sources. The external concerns were frequently of an interorganizational nature and as well were consistently viewed in the context of more than one other organization. For this reason a three level model for analysis of specific organizational concerns would merit consideration.

The major difficulty with this approach was in the definition of the boundaries of the analysis. In regards to this study, the writer experienced two principal areas which, though resolved in theory became blurred in application of the theory to actual organizational events. Specifically, there were problems encountered in differentiating the interface of Level II and Level III and similarly in placing a finite boundary on the organizations which were to be incorporated into the overall interorganizational field.

Both Level I and Level II are clearly differentiated from one another and each can be used successfully to analyse organizational relationships because they deal with a single organization. However, the third level of analysis is not so discreet a concept. Conceptually, analysis at the intra, inter, and
supraorganizational levels should afford a comprehensive view of any organizational concerns but there were frustrations encountered in applying the third and most abstract concept of a suprasystem of organizations to the available data base. As indicated in the earlier chapters of this study there are unfortunate characteristics of the concept which do not lend themselves to easy assimilation. In particular the attempt to analyse a group of independent organizations as a unit was problematic as was the attempt to limit the size of the unit. These two points were seen as the most difficult obstacles to overcome.

Five Dimensions of Analysis

The success in the attempt to analyse interorganizational relationships at three levels of interaction on the basis of five separate dimensions requires some qualification. On the positive side it was relatively easy to identify factors at each of the three levels of analysis which related to the selected dimensions. The only exception in this study was the dimension of interorganizational coordination as applied at the first level of analysis. This may simply have been a function of the subjective nature of the data base which was gathered in the research interviews.

The major difficulty seen in using the five dimensions was again related to problems of boundary definition. In the an-
yses presented in this study it is evident that the dimensions are not discreet. Most notably the concept of resources was fundamentally interwoven with the concepts of power, organizational autonomy, domain consensus, and to a lesser extent with interorganizational coordination. Similarly the effects of power, organizational autonomy, and domain consensus were frequently observed to be related to each other in the analysis of interorganizational relationships at all three levels. However, while this problem of differentiation was a concern, it was not seen to be a major obstacle to the analyses which were attempted.

No observations are made here in regard to the relative success of the use of these specific five dimensions in exhausting the analysis of interorganizational relationships. In the absence of any more objective evaluation of the application of these dimensions it is not possible to rate their relative importance, although the writer has the impression that the five, as a group, were sufficiently comprehensive to address most of the issues which were raised in the research interviews. A number of other dimensions may exist which would have been valuable supplements to this type of analysis. However, it is the opinion of the writer, in view of the extent to which the chosen dimensions were able to be applied to the analysis that those dimensions were among the most appropriate which might have been selected.
Implications

In addressing the various factors which were revealed in the course of this study there is a logical progression of thought which seems to reflect the systems theory concept of ever-widening circles of concern. If the systems concept can be applied to the localized field of community mental health care in Kitimat and Terrace, British Columbia then what are the implications of extending these concepts to broader views of the community mental health care field and other related fields of social policy and planning?

Conceptually, it should be possible to identify a base system and then to subsequently identify the corresponding subsystems and suprasystem relating to that system. As stated above, however, there are some practical considerations which must be taken into account. Boundary setting and definition of base systems have already been cited as areas which have proven to be difficult to reconcile and no further comment is offered here. The other major difficulty which has not been previously discussed in this thesis was the problem of evaluating the nature of interorganizational relationships. The literature does not fully come to grips with all three levels of analysis in suggesting criteria for measuring interorganizational relationships. The writer is of the opinion that methods for obtaining certain
quantifiable objective data may be developed through use of appropriate research techniques. The frequency of organizational contacts, the exchange of certain tangible resources and other such data could no doubt be collected. However, in the presence of other non-quantifiable resources such as information, knowledge, and experience which can affect an organization's exchange relationships may give such an inventory of exchanges very abstract characteristics. In addition, depending on the number of systems within the suprasystem which is being discussed, the volume of interorganizational exchanges may become extremely high. This would likely complicate further the efforts to quantify relationships.

These considerations notwithstanding it seems that advantages should accrue to organizations using an interorganizational approach to their planning efforts. The basic reason for making that statement is that the approach gives organizations an opportunity to view themselves not only on an internal basis but on as broad an external basis as that organization deems necessary.

In the field of community mental health where the number of jurisdictions are quite numerous there should be incentives for organizations to plot their future endeavours with a more complete knowledge of the activities of other organizations with which they interact. Indeed, the exercise of identifying the structure and processes of the suprasystem within which community
mental health organizations function may bring to light a variety of organizational alternatives which were never previously recognized.

While the above comments apply to other fields of social policy and planning the degree of centralization within that field will likely qualify the utility of an interorganizational approach to planning, especially for the organizations of which the field is composed. Clearly, there has to be some flexibility in the operations of individual organizations before such an approach can have merit. Consequently in a more highly centralized field such as education there may be fewer advantages realized by individual schools and school boards or universities and technical schools which are directly controlled by a central government agency.

Nonetheless, from the point of view of a central planning or policy making agency, as opposed to the individual organization's perspective above, all the advantages should apply. If responsibility for overall operations of many organizations falls within a certain jurisdiction then that jurisdiction must have understanding of the interorganizational field for which it is responsible. It must also remain cognizant of the individual systems and suprasystems within which each of those subordinate organizations may function. For example, any bureaucratic hierarchy may have a progressively larger domain as the bureauc-
racy proceeds downward to its lowest level. At each level, the various departments, divisions, or agencies composing the hierarchy may have interactions with other organizations outside the bureaucratic structure. If any central planning agency is to be effective in discharging its responsibilities, regardless of the degree of flexibility in the system, it seems imperative that this central body should be able to identify interorganizational relationships which occur at these lower levels of the bureaucracy.

Suggested Areas For Future Research

The major limitations of this present research have been identified. The questions of boundary definitions and evaluation have been addressed elsewhere in this conclusion. A final limitation that must be mentioned is that the study made use of a very subjective data base. In future studies of this kind it may be useful to attempt to develop a research tool which would be effective in gaining more objective information for analysis. Further to this an attempt should be made to develop more definitive dimensions for purposes of analysis or failing that, to focus on one specific dimension.

The three level approach in the opinion of the writer is extremely intriguing. An attempt to more satisfactorily define and demonstrate the utility of the suprasystem approach in particular is warranted.
REFERENCES


Canada. 1966c Royal Commission on Health Services - Psychiatric Care in Canada: Extent and Results by Alex Richman. Ottawa: Queen's Printer.


Coates, Donald B. 1972 "The Role of the Psychiatrist in Primary Health Care." Unpublished paper presented to the Community Health Centre Project.

Coates, Donald B. 1975 "Mental Health Aspects of Primary Health Care: A Commissioned Paper to the Community Health Centre Project." Ottawa: Canadian Public Health Association.


Klein, Donald C. 1968 *Community Dynamics and Mental Health*, New York: John Wiley and Sons.


APPENDIX I
Map of Kitimat-Stikine Regional District, 1973
APPENDIX II
APPENDIX II

INVENTORY OF MENTAL HEALTH ORGANIZATIONS

Alice Olsen Home

The purpose of the Alice Olsen Home is to provide a home living environment for retarded children brought in to Terrace from areas where there are no special education facilities available. Attendance at the Jack Cook School for the Mentally Retarded is compulsory for the children.

In addition to this more formal education provision, each child is involved in an in-home self-care social and motor development programme. There is provision for continuity in the individual programmes between the Home and the Jack Cook School.

Admission to the Alice Olsen Home is subject to the approval of a committee composed of representatives from the Public Health Unit, Department of Human Resources, the Skeena Mental Health Unit, the paediatrician from Terrace, and the houseparents of the facility.
Cerebral Palsy Association: Terrace Branch

The purpose of this organization is to promote the establishment of treatment and educational programmes for cerebral palsied and other physically handicapped educable children. To this end the Child Development Centre has been established.

The Terrace Cerebral Palsy Association is one of 13 similar partially autonomous organizations in British Columbia. The parent body, the British Columbia Cerebral Palsy Association, fills the liaison gap between its member organizations and the Provincial Government. The Provincial Association acts in an advisory capacity to the local organizations and aided the Terrace Cerebral Palsy Association in locating start-up and maintenance funding, as well as staffing and programme assistance. There is an annual meeting at which all the local Cerebral Palsy Associations meet with the parent organization to democratically and judiciously distribute the annual government grant.

The Terrace Cerebral Palsy Association exists, in effect, to sustain the Terrace Child Development Centre. It organizes local funding campaigns for on-going maintenance of the Centre and has been active in attempts to lobby for and secure both land and financing for a new Child Development Centre.
The Child Development Centre

The Child Development Centre (C.D.C.) is a diagnostic, treatment, and pre-school education centre for children with various neuro-muscular dysfunctions, such as cerebral palsy, blindness, speech and hearing impairments, mental retardation, or behaviour problems. Services are offered by an interdisciplinary group of professionals: a consulting physician, a speech therapist, a physiotherapist, and an executive director who are salaried by the Cerebral Palsy Association of British Columbia - Terrace Branch; a pre-school teacher and a teacher's aide funded by the Department of Human Resources.

The catchment area is roughly coterminous with School District #88. A professional advisory committee to the Board is composed of representatives from public health, social work, special education, and the medical profession.

Department of Human Resources - Region #7

The Department of Human Resources is a provincial government agency that administers services pertaining to legal protection of children, maintenance of children in its care, adoption, specialized child care treatment resources, social allowances, pharmacare, income assistance to the handicapped, and various
education and vocational rehabilitation services.

Region #7 of the Department of Human Resources covers a vast section of northwest British Columbia from the Queen Charlotte Islands east to Burns Lake.

Inter-Agency Consultation on Children with Learning Difficulties

The purpose of the committee is to gain input from member agencies regarding family and social problems, of special education students outside the school context. The committee is also concerned with inadequacies it perceives within the community in terms of psychiatrically trained professionals, and residential facilities for emotionally disturbed and delinquent children.

The inter-agency committee is comprised of volunteer professionals from mental health services, public health, Department of Human Resources, physicians, and school teachers.

The Jack Cook School

The Jack Cook School is an educational facility for mentally and emotionally handicapped children under the age of 18. It is co-sponsored by the Department of Education and the Department of Human Resources.
The catchment area is coterminous with the geographic boundary of the Department of Human Resources Region #7.

The Alice Olsen Home, operated by the Department of Human Resources, is a residence for students attending the school, whose homes are outside Terrace.

The stated philosophy of the School is to guarantee human dignity and prepare students to live as normal an existence as their capabilities will allow. In operationalizing this philosophy, there is considerable flexibility in the individual programmes for children attending the school.

**Osborne Guest Home**

The Osborne Guest Home is a boarding home primarily for mentally handicapped adults. It attempts to function as a personal care facility and offers training in basic living through programmes within the residence and utilization of outside resources.

Funding is provided by the Department of Human Resources at the rate of $14 per person per day, or if funded through private resources the rate is $300 per person per month.
Skeenaview Lodge

The Skeenaview Lodge is a 170-bed multi-level psychiatric facility for the rehabilitation and reactivation of elderly males.

Until July 1, 1974, Skeenaview Lodge was part of the Provincial Government's Mental Health Service and was used as an annex to the Riverview Hospital in the lower mainland. The hospital has since been taken over by the Department of Human Resources in order to take advantage of shared cost grants from Ottawa under the Canadian Assistance Plan.

Its present catchment area is supposed to be the four regional districts of Kitimat-Stikine, Bulkley-Nechako, Skeena-Al, and Stikine (unincorporated), and other regions located in the northeast of British Columbia.

Skeena Mental Health Centre (Mental Health District #4)

The Skeena Mental Health Centre is one of 17 (1972) provincially funded Community Mental Health Centres under the jurisdiction of the British Columbia Department of Health, Mental Health Services.

This unit is responsible for providing a broad spectrum of mental health services to individuals in a geographic area from
Kitimat in the south to the B.C.-Yukon border in the north, and from Terrace in the west to Houston, Gran Isle, and Smithers in the east.

Professional staff consists of two psychiatric social workers, one psychiatric nurse. This complement is subsidized by monthly week-long visits from a psychiatrist from Mental Health Services Branch in Victoria, B.C.

Terrace Association for the Mentally Retarded

The purpose of the Terrace Association for the Mentally Retarded (T.A.M.R.) is to promote the education, development, and welfare of all mentally retarded, and to educate the general public in the field of mental retardation.

The membership of the Association is comprised of concerned individuals from within the community. A great deal of the activity of the Association has been directed towards eliciting community support and initiating projects in support of the mentally retarded. The Association was instrumental in securing funds and facilities to begin both the Alice Olsen Home and the Three Rivers Workshop.
Terrace and District Community Resources Society

The Terrace and District Community Resources Society was incorporated under The Societies Act in 1973 but had existed as an agency since early 1972. The agency was comprised of people in the core service agencies who were concerned that the growing needs of the community of Terrace were being met effectively without duplication of services. To this end the agency attempted to determine "public awareness of existing services and their effectiveness" and to subsequently determine "public opinion on additional services of an immediate and future nature" (Terrace Report, 1974, p.1).

The format of the Society, since incorporation in 1973, has taken on the Community Resource Board model developed by the Department of Human Resources. The purpose of the Community Resources Board (C.R.B.) is to provide local solutions to local needs through the administration and coordination of non-statutory social services in the Terrace area.

Ultimately the C.R.B. will be composed of publicly elected members under the new Resources Board Act 1973, rather than elected members of the Society as is currently the practice. The Terrace C.R.B. has been slated as one of a number of similar
Boards throughout the province to go to public elections in the near future. A task force is to be assembled in Terrace to organize and coordinate the public election.

Funding for the operation of the C.R.B. is provided by the Community Grants Division of the Department of Human Resources. These funds are to enable the C.R.B. to act as the administrative and coordinating agency for programmes it decides to sponsor within the community.

Three Rivers Workshop

The Three Rivers Workshop is an activity centre attempting to serve all handicapped adults in the Terrace area, with work experience, reaction, and education.

The workshop began its functioning through the activities of the citizens of Terrace. Initial funding through L.I.P. grants has been discontinued. The Provincial Government, through the Department of Human Resources, has provided a much smaller activity grant than is sufficient for maintaining the present level of activity in the workshop.

The workshop has attempted to become self-sustaining through sale of manufactured products, such as wooden toys and planters.
Kitimat Child Development Centre

This is a treatment centre for children with physical and mental handicaps. This centre is affiliated with the Cerebral Palsy Association of B.C.

Funding is from two sources:
1. Provincial Department of Resources
2. Provincial Cerebral Palsy Association

Staff consists of a part-time physiotherapist, part-time speech therapist, part-time teacher for deaf children, the executive director, a pre-school teacher, and office and clerical staff.

Assessment of children is made by physiotherapist, speech therapist, pre-school teacher, paediatrician, and on occasion childrens' diagnostic centre in Vancouver. Referral from a physician is required.

Cormorant School

The Cormorant School, an elementary school within School District #80, has been the location of a one-room facility for the operation of an education programme for the Trainable Men-
tally Retarded children in Kitimat. One teacher and one child
care worker provide individual programming for children who
attend the class. Enrollment numbers between 8-10 students.

Kitimat Association for the Mentally Retarded

The function of this association is to better the lot of
mentally retarded children, and to provide support and guidance
to their parents. It has a 15 member directorate, 5 of whom
serve on the council.

Programmes supported by this association are:

1. Kitimat Workshop
2. Future development of a short stay facility so families
can be given a rest from the demands of a mentally re-
tarded child.

The Kitimat Community Services Society

The Kitimat Community Services Society was incorporated
under The Societies Act in 1973. The objects of the Society are
to define local needs in the area of community services and to
establish priorities for meeting these needs; to ensure that
agencies within the community are aware of the community prior-
itides; to promote communication between agencies and the general public; and to dedicate whatever monies available to meeting local needs.

The Society is concerned with mental health, housing, youth services, legal aid, and consumer services.

Funding for the organization is provided by the Community Grants Division of the Department of Human Resources, and through local subscriptions and grants. There are no immediate plans for this society to begin functioning as a community resource board (C.R.B.) and consequently there are no plans for public elections of elected board members under the new Resources Boards Act, 1973.

Kitimat Workshop

This is a workshop which was intended to provide training and rehabilitation for mentally and physically handicapped children.

The staff consists of one director and two mentally handicapped assistants who have been employed to supervise and assist in the programme. Ten people attend the workshop regularly.