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ISOMORPHISM AND EXTERNAL SUPPORT IN CONFLICTING INSTITUTIONAL ENVIRONMENTS: A STUDY OF DRUG ABUSE TREATMENT UNITS

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Using institutional theory, we developed predictions about organizational units that moved from an environment making consistent demands to one making conflicting demands. Many community mental health centers have diversified into drug abuse treatment. The units providing those services face conflicting demands from the traditional mental health sector and the new drug abuse treatment sector about which clients to serve, how to assess their problems, and who should provide treatment. We propose that in response to such demands these units will adopt apparently conflicting practices. Also, isomorphism with the traditional sector will be positively associated with external support from parent mental health centers and other actors in the mental health sector. Results generally support those predictions.

Institutional theorists have argued that widely held beliefs and rules in the environments of organizations often influence their structure and behavior, irrespective of their technologies and resource exchange relationships (Scott, 1987; Zucker, 1987). When organizations face environments characterized by strong belief systems and rules, survival and effectiveness depend more on the legitimacy acquired from conforming to widely held expectations than on efficient production (DiMaggio & Powell, 1983; Meyer & Rowan, 1977). Conforming to strong environmental beliefs and rules is difficult for many organizations, however, because they face fragmented environments in which multiple independent groups and organizations make demands that are, at best, uncoordinated (Meyer, Scott, & Strang, 1987; Powell, 1987). It is especially difficult for organizations to adapt to fragmented environments characterized by disparate values and conflicting beliefs about

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appropriate structure and behavior. In Meyer and Rowan's view, "Institutional environments are often pluralistic and societies promulgate sharply inconsistent myths" (1977: 356).

This study examined organizational units that, as a result of diversification, moved from an environment presenting relatively consistent demands to a fragmented environment presenting conflicting demands. After diversification, these units were exposed to new beliefs and practices that conflicted with traditional ones.

We addressed two related research questions about the practices these units adopted. First, how do organizational units respond to new external demands that conflict with their traditional practices? Meyer and Rowan (1977) argued that it is too risky for organizations to choose among beliefs and adopt only those that produce internally consistent practices. Rather, organizations adopt inconsistent, even conflicting, practices to gain legitimacy. But we argue further, following an ecological perspective (Hannan & Freeman, 1984), that organizations have limited ability to respond to conflicting demands and thus will conform to them only partially.

Our second question concerned the consequences of the practices the units studied adopted. We examined the relationship between units' use of traditional practices and their support from parent organizations and other external sources. The proposition that organizational isomorphism is rewarded with external support is a persistent theme in institutional theory (Meyer & Rowan, 1977), but little research has focused on the consequences of isomorphism. Most research in institutional theory concerns the causes of isomorphism, especially conditions under which organizations in the same sector adopt similar practices or structures (e.g., Oliver, 1988).

Our analysis examined two sectors of the health care industry that hold conflicting beliefs about the treatment of substance abuse clients: the mental health and drug abuse treatment sectors. We examined a representative national sample of units of mental health centers that have diversified to provide drug abuse treatment services. As a result, the "hybrid units" face conflicting pressures from the two sectors.

DiMaggio and Powell (1983) asserted that institutional analyses of organizations should begin by examining the content of environmental beliefs and practices. Thus, we begin by describing the fragmented environments, conflicting beliefs, and recent changes in the mental health and drug abuse treatment sectors of the health care industry. Our description of these sectors draws on numerous published sources (e.g., Blane & Leonard, 1987; Blum & Roman, 1985; Fingarette, 1988; Robertson, 1988).[1]

[1] In addition, the research team that gathered the quantitative evidence presented here also conducted two sets of case studies of mental health centers that provide drug abuse treatment services. Three members of the research team conducted one set to develop a conceptual model and survey instruments for the present study (Burke, D'Aunno, & Price, 1983). The study consisted of one-to-two-hour-long semistructured interviews of the directors, clinical supervisors, and staff members ($n = 30$) of nine organizations on topics including history, organization (continued)

SECTOR ORGANIZATION AND RATIONAL MYTHS

Fragmented Sector Organization

There are multiple and often uncoordinated sources of legitimacy in the mental health and drug abuse treatment sectors of the health care industry. At the federal level, each sector has an institute concerned with research and policy issues, the National Institute on Mental Health and the National Institute on Drug Abuse. At the state level, separate offices manage, fund, and regulate treatment services. In both sectors, treatment organizations obtain funds from sources including state offices, clients' fees, donations, and insurance firms. Figure 1 summarizes the organization of the sectors.

Treatment organizations in both sectors typically have complex networks consisting of state and federal agencies, professional associations and advocacy groups, and licensing and funding groups (Burke et al., 1983). Some of these organizations have formal authority over aspects of client treatment, and others have informal influence. But none has the authority to coordinate or reconcile conflicting rules and beliefs.

Rational Myths in the Mental Health and Drug Abuse Sectors

Meyer and Rowan (1977) defined "rational myths" as widely shared societal rules and belief systems. Such myths about client treatment play an important role in the behavior of mental health and drug abuse treatment organizations. We use the term "rational myths" rather than the term "technology" because scientific knowledge about the causes and effective treatment of client problems is weak, inconclusive, and contradictory in both sectors (Hasenfeld, 1983). Drug abuse treatment organizations work with highly uncertain technologies. Hasenfeld argued that the beliefs of managers and staff members provide the justification for decisions about client treatment "since these cannot be derived from a coherent body of knowledge" (1986: 142).

Complex and conflicting beliefs about treatment exist within each sector as a result of such technological uncertainty (Caragonne, Emery, & Isser, 1987; Meyer, 1986). These belief systems have evolved over time and continue to change. But one general model is dominant in each sector (Roman, 1988). In the mental health sector, the dominant model is the psychosocial model, according to which mental health problems develop in part because of such stressful events in a person's environment as work stress and the death of a spouse and in part because of the person's failure to cope with

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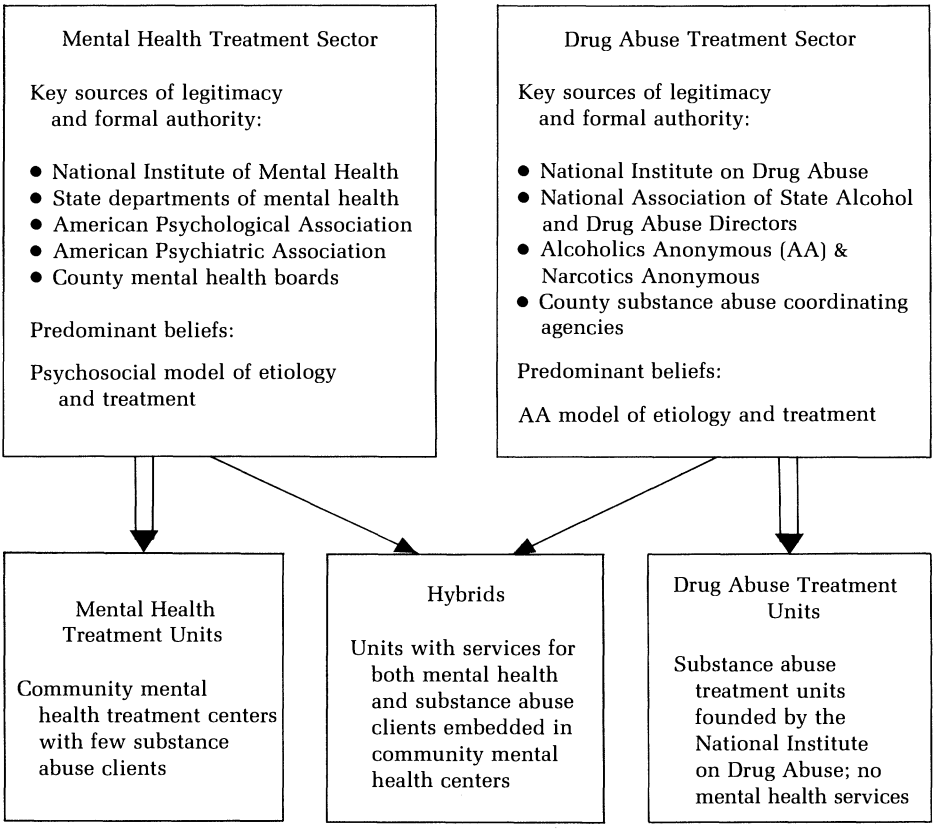
structure, staff characteristics and attitudes, budget size and fluctuations, services offered, ownership, treatment philosophy, relationship with the parent organization, social stigmata, competition, conflict, and future changes. In the second set of case studies, eight organizations were randomly selected from the sample used in the current study, and one or two members of the research team visited each site. They conducted six to eight interviews at each site, using a methodology similar to that in the first case studies. These data were the basis for a written summary of the eight cases.

FIGURE 1
Environmental Forces and Organizations in the Drug Abuse and Mental Health Treatment Sectors



such events. Maladaptive responses are thought to include substance abuse, depression, and anxiety. Effective treatment consists of altering environmental demands and modifying coping responses by, for example, helping the person to relax, become assertive, or express emotions to others.

These beliefs shape the organization of mental health services, which hire professionals, including psychiatrists, psychologists, and social workers, who are trained to diagnose sources of stress and maladaptive responses. A central rational myth is that professionals should diagnose clients using psychological tests or classification systems such as the *Diagnostic and Statistical Manual of the American Psychiatric Association* (third edition), which we subsequently refer to as DSM-III. These diagnostic approaches are rational in that they provide procedures for assessing mental health. These approaches are myths in that their use depends heavily on endorsements by professional associations (e.g., the American Psychiatric Association), ac-

creditation bodies (e.g., the Joint Commission on Accreditation of Health Care Organizations), and financial sources (e.g., Blue Cross).

In contrast, the Alcoholics Anonymous (AA) model of etiology and treatment dominates the drug abuse sector (Blum & Roman, 1985), within which alcohol and drug abuse are believed to be diseases that can be treated only when clients abstain completely from abused substances and take responsibility for helping themselves. Advocates of this model view psychological tests as unnecessary because all clients have the same problem and can all be treated through the same methods. Effective treatment can begin only after individuals recognize that they are ill and have the desire to recover. Further, clients are always recovering because their continued good health depends on complete abstinence. Support for individuals' recognizing their illness and continued recovery comes from recovering alcoholics or drug addicts, not professionals.

The AA model shapes the organization of treatment services. Complete abstinence from drugs or alcohol is typically a prerequisite for admission to treatment, and clients are closely monitored for compliance. Treatment providers hire ex-addicts or ex-alcoholics as counselors because they have firsthand knowledge of AA's 12 "steps to recovery." These steps are rational because they prescribe how to achieve recovery; they are myths because their acceptance and use depend on their promotion by Alcoholics Anonymous and its members.

Evolution in the Organization of Sectors

The drug abuse and mental health treatment sectors are so organized that treatment for drug abuse is provided in three distinct types of settings. First, the National Institute on Drug Abuse has founded units that provide only drug abuse treatment services (see Figure 1). These units, which provide most of the outpatient treatment services for this problem in the United States, are rooted in the drug abuse treatment sector by virtue of their histories. We termed these "drug abuse treatment units." Second, some community mental health centers with no special units for drug abuse treatment provide such services on an ad hoc basis. We termed these "mental health treatment units." Third, in the last several years a large number of community mental health centers have diversified into drug abuse treatment either by adding this service to an existing unit or by forming a new unit (D'Aunno & Price, 1985). Though the causes of this trend have not been systematically examined, reduced or stagnant levels of public funding for mental health treatment may have prompted some mental health centers to diversify into drug abuse treatment in order to increase revenues. We termed these units "hybrids" because they also serve mental health clients. As a result of such diversification, hybrids have moved from an institutional environment that presented relatively consistent demands to an environment that presents conflicting demands. Hybrids have been exposed to new beliefs and practices that conflict with the mental health practices traditional in the sector of their origin.

ORGANIZATIONAL RESPONSES TO CONFLICTING EXTERNAL BELIEFS

Hybrid units face powerful pressures to abandon traditional practices in favor of new beliefs and practices. The first pressure is the desire to achieve legitimacy in the new drug abuse sector by conforming to its practices. Hybrids encounter pressure to rely more on practices prevalent in the drug abuse sector than on prevalent mental health practices. Organizations that provide client referrals, for example, may not support hybrids unless they use AA practices. Hybrids may hire recovering addicts and alcoholics rather than professionals to gain acceptance from such referral organizations and from AA groups and peers in drug treatment organizations. Scott (1987) described this type of institutional pressure as "inducement."

A second pressure against using traditional mental health practices is evidence for the effectiveness of the newer, conflicting practices. Compelling evidence for the superior effectiveness of an alternative approach can tempt managers to abandon long-standing practices and to adopt new ones. Some empirical studies of AA treatment approaches and powerful testimonial evidence have indicated that the AA model is more effective than the psychosocial approach for substance abuse treatment.[2] Managers of hybrids who encounter and accept such evidence might be tempted away from psychosocial practices. Hybrids may, for example, rely less heavily on psychological diagnostic tools than mental health units do because such tools are unnecessary in the AA model.

Proponents of the AA approach have developed and disseminated an emotionally compelling literature to support their beliefs. This literature began with *Alcoholics Anonymous* (known as the Big Book), which was written in 1939 by Bill Wilson, one of the organization's two founders. The Big Book has sold more than 5 million copies, and its influence persists: about 800,000 copies were sold in 1986. As a result of this emotionally compelling evidence, managers of hybrids may voluntarily adopt practices from the drug abuse treatment sector. Scott (1987) termed such voluntary adoption "acquisition of organizational structure."

One perspective of how hybrid units will respond to these conflicting pressures follows from Meyer and Rowan (1977). They argued that it is too risky for organizations to choose among beliefs and adopt only those that produce internally consistent practices and that instead, "Organizations in search of external support and stability incorporate all sorts of incompatible structural elements" (Meyer & Rowan, 1977: 356). We agree with their perspective and propose that hybrid units will adopt at least some practices and beliefs from both their traditional and their new institutional environments.

[2] There is, however, considerable debate about the quality of scientific evidence supporting the AA model; critics claim that AA proponents have intentionally distorted early studies by Jellinek (1960) and used invalid data to promote their views (Fingarette, 1988).

At the same time, however, we assert that there are limits on organizations' ability to respond to their environments. Thus, organizations faced with new practices that conflict with traditional ones will respond on the basis of two criteria.

First, organizations will rank new practices in terms of a hierarchy of institutional demands. Not all institutional pressures are equally important. Organizations will respond to demands in the order of their importance for organizational legitimacy. Organizations conform primarily to those beliefs and practices in a new institutional environment that are necessary for gaining a minimum level of legitimacy in that sector. At the same time, they retain key practices legitimized in their traditional sector. Practices are combined in ways that satisfy some important institutional demands while minimizing disruptive transformations in established patterns of behavior.

Second, organizations will adopt and combine practices on the basis of their visibility to external groups, which cannot easily monitor all organizational practices and beliefs. Organizations may try to create the impression that they are adopting the beliefs and demands of external groups by showing visible signs of conformity. Meeting demands from the environment is insufficient; some elements of conformity must be noticeable to external groups.

Hiring appropriate employees is a critical way to gain a minimum level of legitimacy and conform visibly to external demands (Meyer, Scott, & Deal, 1981; Scott & Meyer, 1983: 141). Beliefs about who should conduct therapy are important in both the mental health and drug abuse sectors. The psychosocial model and the AA model each prescribe an ideal therapist, in the first case, a professional, and in the second, an ex-addict. Therapists are visible. Thus, we expected hybrids to have hiring criteria and practices that reflect both the psychosocial and the AA model of substance abuse. Although it is apparently contradictory, this combination is likely to occur because it allows hybrids to conform visibly to a key belief in each sector. Mental health units do not face as much pressure to hire ex-addicts as do hybrids, and they have little reason not to rely on professionals. Similarly, drug abuse treatment units face little pressure to hire professionals and are likely to rely on ex-addicts, as AA prescribes. Thus,

> *Hypothesis 1a: Hybrids will emphasize hiring professionals more than drug abuse treatment units will.*

> *Hypothesis 1b: Hybrids will emphasize hiring ex-addicts more than mental health treatment units will.*

We argued that hybrids will respond to pressures from the drug abuse sector in a limited way. In particular, hybrids will differ from drug abuse treatment units in the extent to which they insist on complete abstinence from drug use as a treatment goal. In the psychosocial model, the goal of treatment is not abstinence from drugs, but instead, changing the underlying causes of drug abuse. Thus, we expected that hybrids will place less emphasis on complete abstinence from alcohol or drugs than drug abuse treat-

ment units. This proposition is consistent with the view that organizations have limited ability to respond to environmental demands. We expected that the psychosocial model will continue to influence the dominant values of hybrids.

Hypothesis 2: Hybrids will not emphasize complete abstinence from drug use as a treatment goal as much as drug abuse treatment units.

Similarly, the psychosocial model will continue to influence many other treatment practices in hybrids. In particular, we expect hybrids to conform to the mental health practice of using DSM-III routinely in client diagnosis and assessment. Hybrids will not adopt inconsistent practices, as the Meyer and Rowan perspective suggests, by using this diagnostic tool with only some clients. Proponents of the AA model view the use of such diagnostic approaches as unnecessary because all clients are thought to have the same problem and to need the same treatment. In the mental health sector, however, diagnosis through DSM-III is viewed as a necessary preamble to an individual's treatment, and its consistent use is a criterion for obtaining key accreditations (e.g., from the Joint Commission on the Accreditation of Health Care Organizations) and payments (e.g., from Blue Cross). Thus,

Hypothesis 3: Hybrids will use DSM-III more routinely to assess clients than will drug abuse treatment units.

Finally, ecological theory suggests that after diversification some hybrids may remain more isomorphic with the mental health sector than others. Hannan and Freeman (1984) proposed that large, old organizations are less likely than small, new units to change core features such as goals and technologies. Substantial changes in large organizations are difficult because they develop complex sets of routines to ensure reliability and persistence in performance. These routines are likely to be institutionalized as organizations age, making the organizations resistant to change in core features. Important groups in the mental health sector may inhibit change in hybrids by rewarding isomorphism (DiMaggio & Powell, 1983; Scott, 1987) and by making it difficult to alter network ties (Zucker, 1987). For example, licensing and accreditation requirements imposed by state agencies and insurance firms can influence hybrids to retain traditional methods of diagnosis and treatment. Thus,

Hypothesis 4: Large, old hybrid units are more likely to hire professionals and use DSM-III routinely and less likely to emphasize complete abstinence as a treatment goal than smaller and younger hybrids.

HYBRID UNIT ISOMORPHISM AND EXTERNAL SUPPORT

The first four hypotheses concern how hybrid units will respond to conflicting environmental pressures through the adoption of apparently in-

compatible hiring and treatment practices. We now turn to the price that hybrids may pay for such lack of conformity to practices in the traditional mental health sector. We contend that hybrid units that rely less on the psychosocial model and more on the AA model will have difficulty maintaining support from the mental health sector. The rational myths promulgated in the mental health sector prescribe that, if hybrids are to conform to traditional practices, isomorphism is essential in three core features: client characteristics, technologies and goals, and personnel training and socialization. The organizational practices that establish isomorphism in those areas are mixing abuse clients with clients who have other mental health problems rather than serving only drug abusers, using psychological tests rather than labeling all clients as drug abusers, and hiring professionals rather than recovering substance abusers. If a unit is similar to others in its traditional sector along those three dimensions, it is unlikely that its conformity and legitimacy will be questioned. In contrast, units that abandon or deemphasize those three features risk a loss of external support from their traditional sector. We develop this argument below in a series of hypotheses concerning hybrid isomorphism and external support from parent organizations and other mental health sources.

Parent organizations have resources to coerce or induce subunits to conform to parents' beliefs and practices (Scott, 1987). Further, parent organizations can often monitor conformity more closely than other external organizations. The parent organizations in this study were community mental health centers, which themselves faced pressures to conform to the beliefs and practices of the mental health sector and thus expected hybrids to use such practices. The parents controlled incentives for conformity, including funds, personnel, and materials. Furthermore, when hybrids conform to such expectations, their members are likely to receive acceptance and social-psychological support from the members of parent organizations. In contrast, if unit members eschew mental health practices, they may suffer the usual fate of deviants and be ignored or rejected (Goffman, 1963).[3]

These arguments suggest that parent organizations will support hybrids to the extent that the latter are isomorphic with their parents in regard to clients, goals and technologies, and personnel. First, hybrids vary in the extent to which they serve the same clients as their parents and the mental health sector. Hybrids are caught in a catch-22. Their parent organizations have directed them to treat drug abuse clients and, by doing so, they serve their parents' interests. Yet, the greater the proportion of drug abuse clients they serve, the less isomorphic they are with their parent organizations.

[3] It is also possible that parent organizations and hybrid units can be so loosely coupled that hybrids' deviance from or conformity to traditional mental health practices is not noticed or is ignored. We conducted extensive analyses to examine the relationship of loose coupling to hybrid conformity and parents' support. The results indicate that the extent of coupling does not influence the results reported here.

Second, units that place great emphasis on abstinence may be perceived by parents as conforming to the AA model rather than the psychosocial model because this goal signals that treatment is following the 12 steps rather than focusing on underlying causes. Third, hybrids can be isomorphic with their parents by using psychosocial treatment technologies with drug abuse clients. For example, hybrids can use psychological tests to diagnose drug abuse clients. Fourth, to be isomorphic with their parents and the mental health sector, hybrids must hire professionals rather than ex-addicts. Who should conduct treatment is the subject of important rational myths in both the mental health and drug abuse sectors, and staff composition is easy to monitor. In sum, we predict

> *Hypothesis 5a: The greater the isomorphism of hybrid units with the mental health sector, the more resource support they will receive from their parent organizations.*

> *Hypothesis 5b: The greater the isomorphism of hybrid units with the mental health sector, the more social-psychological support they will receive from their parent organizations.*

Hybrids that conform to traditional mental health practices will also receive legitimacy and financial resources from organizations in the mental health sector other than their parents. An organization is legitimate when powerful collective actors endorse its actions (Singh, House, & Tucker, 1986). In the mental health sector, obtaining a license from regulatory agencies that support the psychosocial model indicates legitimacy. Three powerful and pervasive regulators in this sector are the Joint Commission on Accreditation of Health Care Organizations and state and county or regional departments of mental health. To obtain or avoid losing licenses from those regulators, hybrids must label a substantial portion of clients as having mental health problems, even if those clients also have substance abuse problems (Caragonne et al., 1987), diagnose and treat clients with mental health approaches (e.g., use DSM-III), and employ degreed professionals. Each license emphasizes conformity to somewhat different mental health practices. Thus, the more a hybrid conforms to mental health sector practices, the more mental health licenses it can obtain.

> *Hypothesis 6: The greater the isomorphism of hybrid units with the mental health sector, the greater the number of the three primary mental health licenses they will hold.*

Sources of money in the mental health sector have expectations for hybrids similar to those of parent organizations and mental health regulatory agencies. For example, Blue Cross and other insurance firms will pay for substance abuse or mental health treatment only if DSM-III is used because they view that practice as evidence that their beneficiaries are receiving high-quality care. If a hybrid conforms to that and other mental health prac-

tices, it can obtain money from federal and state agencies and private insurance firms. Thus,

> *Hypothesis 7: The greater the isomorphism of hybrid units with the mental health sector, the larger their number of financial sources from that sector.*

Finally, hybrids that conform to mental health practices should not only have more mental health–related financial sources; they should also be able to garner more money from those sources than hybrids that conform to the AA model. For example, a hybrid receiving reimbursement by insurance firms that endorse the mental health approach rather than the AA model can rely less on clients' fees, which are typically lower than insurance payments. In turn, routine use of DSM-III may require hiring mental health professionals. Thus,

> *Hypothesis 8: The greater the isomorphism of hybrid units with the mental health sector, the more financial support they will receive from mental health sources outside the parent organization.*

In sum, we contend that parent organizations, regulatory agencies, and financial sources in the mental health sector create what DiMaggio and Powell (1983) termed an "iron cage," in which conformity among hybrid units is rewarded.

METHODS

Participating Organizations and Individuals

The present study used data from a national study of drug abuse treatment units (D'Aunno & Price, 1985) based on a stratified random sample of 362 units drawn from the total population of 2,337 outpatient drug abuse treatment units in the United States in 1984. The population was stratified according to type of treatment unit: (1) units initially founded and funded by the National Institute on Drug Abuse that did not provide mental health services (drug abuse treatment units), (2) units located in mental health centers and specializing in drug abuse treatment services (hybrids), and (3) units located in community mental health centers that predominantly provided mental health services (mental health treatment units).

The two top managers—the unit director and the director of clinical services—of each of the 362 selected units were asked to complete telephone surveys in the summer of 1984. Each type of manager completed a different survey. Directors provided information concerning their unit's finances, licenses, and external relations, and clinical supervisors provided information about personnel, clients, and treatment. Of the 333 participating units, 48 were mental health treatment units, 195 were drug abuse treatment units, and 90 were hybrids. The overall response rate was 92 percent, and refusal rates did not differ significantly by type of treatment unit. The par-

ticipating units represent a stratified random sample of 14 percent of the nation's outpatient drug abuse treatment units in 1984.

Data Sources and Measures

Treatment unit type. Dummy variables were created assigning each unit a 1 or 0 value for membership in each of the three groups. We used these dummy variables as predictors in testing Hypotheses 1 through 3.

Hiring practices. Two measures of hiring practices were based on clinical supervisors' indication of how much they relied on the following criteria in hiring staff members: professional degrees or credentials and a personal history of substance abuse problems. The first measure was labeled *reliance on professionals*, and the second, *reliance on ex-addicts*. Respondents used a five-point Likert scale ranging from "not at all" (1) to "a great deal" (5). We used these measures as dependent variables in testing Hypotheses 1–4 and as predictor variables in testing Hypotheses 5–8.

Treatment goals and practices. To assess the extent to which units had different goals for treatment, the telephone survey asked clinical supervisors "How important in treatment plans for clients is sobriety or complete abstinence from drug use?" (1 = not important, 4 = very important). This variable was labeled *sobriety goal*. To assess differences among units in their use of the traditional mental health diagnostic tool DSM-III, the survey asked clinical service supervisors whether they used DSM-III routinely (1) or only sometimes (2). This dichotomous dummy variable was labeled *use of DSM-III*. We used these measures as dependent variables in testing Hypotheses 1–4 and as predictor variables in testing Hypotheses 5–8.

Unit age and size. Data from the unit directors established hybrids' *unit age*. We controlled for unit age in the analyses of external support. Old units may receive more external support than young units because relationships with sources of support become institutionalized over time. Conversely, young units might need and receive more support than old units in order to develop services. Size was measured as the total *number of full-time employee equivalents* in 1984 with data from the clinical service supervisor interview. We controlled for unit size in analyses of external support because it is possible that large units receive more external support than small units. Regardless of client demand for services, units that have many employees may seek external support in order to retain them. We used these measures as predictor variables in testing Hypothesis 4 and as control variables in testing Hypotheses 5–8.

Client composition. The percentage of clients served by a unit in the last 12 months whose primary problem was labeled as drug abuse was measured. We used this measure, *percentage of drug abuse clients*, as a control variable in testing Hypotheses 1–4 and as a predictor variable in testing Hypotheses 5–8. A contingency theory perspective (Lawrence & Lorsch, 1967) suggests that the hypothesized pattern of practices for hybrids simply reflects their tasks in treating mental health clients. Hybrids may therefore resemble men-

tal health treatment units more than drug abuse treatment units because hybrids are treating mental health clients and drug abuse units are not, not because hybrids are attempting to conform to environmental demands. Evidence for this alternative explanation can be sought by examining the mix of clients that units treat: if the contingency view is correct, the more mental health clients a hybrid unit serves, the more it would resemble a mental health center. Thus, we controlled for the percentage of drug abuse clients each hybrid unit treated. This variable also indicates the extent to which the clients a hybrid served were similar to the clients served by mental health organizations. The greater the percentage of drug abuse clients that a hybrid serves, the less isomorphic it is with mental health treatment organizations.

External support for hybrids. Five measures of the extent to which hybrids received support from external organizations and groups were based on data gathered in the unit director interviews. We used these measures as dependent variables in testing Hypotheses 5–8. The extent of a *parent's resource support* was assessed with 10 yes or no questions: "Do you receive funds for operating expenses from [name of parent organization]? Do you receive funds for payroll expenses?" "Do you receive support from clerical staff? Administrative staff? Clinical staff? Maintenance or custodial staff? Or any other staff?" "Do you receive supplies? Equipment? Office space?" Affirmative responses were scored 1 and negative responses, 0; affirmative responses were then summed. The extent of a *parent's social-psychological support* for a hybrid and its staff members was measured by "To what extent is your organization and its staff accepted by the community mental health center?"(1, not at all accepted, to 3, completely accepted).

Hybrids can also receive legitimacy and financial support from external organizations in the mental health sector other than their parent. Legitimacy in the mental health sector was measured by the *number of mental health licenses* held. Unit directors indicated how many of three primary licenses their units held: a license from a state mental health department, from a county or regional mental health department, and from the Joint Commission on Accreditation of Health Care Organizations. Each license or accreditation emphasizes different mental health sector practices. Thus, the extent of a hybrid's licenses or accreditations legitimizes it in the mental health sector.

The first measure of financial support from the mental health sector was the *number of mental health financial sources.* Unit directors indicated whether they had received money in fiscal year 1984 from each of three central sources in the mental health sector: federal agencies (e.g., the National Institute of Mental Health), state mental health departments, and private insurance firms (e.g., Blue Cross). For *total mental health financial support*, the second indicator, unit directors were asked what percent of their units' total operating budgets for fiscal year 1984 came from each central source. These percentages were then used to compute the amounts received. Data were missing for 13 cases on this variable, resulting in a regression analysis with 77 rather than 90 cases.

Control variables. We controlled for the possible effects of three variables on the practices and the external support of hybrid units. The first, used in testing Hypotheses 4–8, was *director's experience*. Experienced directors may be more skillful than inexperienced ones in resisting efforts by external groups in the new drug abuse sector to influence their units' practices and goals and thus more likely to rely on traditional mental health practices. Similarly, experienced directors may be more skilled at securing external resources and support. Using data from the director interview, we developed a two-item measure combining the number of years directors had been employed by their units and the number of years they had been in the field of mental health or drug abuse ($\alpha = .68$).

The second and third control variables were used in testing Hypotheses 5–8. Parent organizations and other mental health sources may reward hybrids for efficiency rather than for conformity to traditional practices. We used data from the clinical supervisor survey to measure efficiency by dividing the *total number of clients served in 1984 by the total number of full-time employee equivalents*. The higher this ratio, the more efficient the hybrid in producing services. Finally, the amount of external support hybrids receive could be related to their need for support. The more clients a hybrid serves, the more resources it may need and receive. Data from the clinical supervisor survey provided the measure representing the total *number of clients* served in 1984.

Table 1 gives zero-order correlations and descriptive statistics for all the variables.

Analysis

Three sets of analyses were conducted to test the hypotheses. First, to test Hypotheses 1–3, we conducted multinominal probit analyses relating unit type and client mix to hiring and treatment practices. Multinominal probit is particularly useful when the dependent variables of interest are ordinal, or form ordered multiple categories (Aldrich & Nelson, 1984; McKelvey & Zavonia, 1976), as do the dependent variables in this study. This approach can be viewed as an analogue to regression analysis with categorical dependent variables. In the probit analyses, we excluded the dummy variable for hybrid units to avoid overspecifying the model; thus, we interpreted the coefficients for drug abuse and mental health units as comparisons to hybrid units.

Second, to test Hypothesis 4, concerning hybrids' size and age as predictors of practices, we conducted multinominal probit analyses for hybrid units only. This subgroup analysis included controls for the effects of client mix and director experience on hybrids' practices. Third, we conducted multiple regression and multinominal probit analyses to test Hypotheses 5–8, concerning the relationships between hybrids' hiring and treatment practices and their external support.

TABLE 1
Means, Standard Deviations, and Intercorrelations for All Variables[a,b]

Variables	Means	s.d.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1. Hybrids	0.36	0.48																	
2. Mental health treatment units	0.13	0.33	−.29																
3. Drug abuse treatment units	0.51	0.50	−.77	−.39															
4. Reliance on professionals	4.17	0.90	.11	.12	−.19														
5. Reliance on ex-addicts	2.12	1.07	−.01	−.16	.11	−.24													
6. Sobriety goal	3.78	0.68	−.02	−.16	.13	−.01													
7. Use of DSM-III	1.33	0.88	.32	.25	−.47	.21	−.12												
8. Percentage of drug abuse clients	86.84	25.32	.11	−.32	.10	−.11	.08	.00											
9. Unit age	10.75	5.61	.02	.16	−.12	.01	−.14	−.09	.04										
10. Full-time employee equivalents	7.47	7.64	−.05	.08	.00	.06	−.08	−.15	.03	−.20									
11. Director's experience	19.12	8.42	.09	.07	−.13	−.09	.05	.04	.09	−.03	.22								

TABLE 1 (continued)

Variables	Means	s.d.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
12. Parent's resource support	5.72	3.85				.17	−.22	.01	.07	−.26	.23	.08	.00						
13. Parent's social-psychological support	2.72	0.46				.12	−.10	−.03	.12	−.16	−.07	−.17	.00	.02					
14. Total mental health financial support	27.61[c]	41.21				.17	−.05	−.02	−.12	−.45	.12	.46	.21	.11	.14				
15. Number of mental health financial sources	2.32	0.70				.10	−.10	−.05	.14	−.24	.23	.27	.03	.27	.25	−.05			
16. Number of licenses	1.13	0.82				.05	−.30	−.28	.13	−.12	.06	.12	−.07	.09	.10	.03	.17		
17. Number of clients/number of full-time employee equivalents	85.46	70.12				−.02	−.10	−.12	−.03	.05	−.05	.57	.08	.11	−.20	−.12	.07	−.05	
18. Number of clients	584.43	664.42				.04	−.06	−.08	−.10	−.23	.24	.49	.13	.07	−.34	.14	.18	.04	.50

[a] Variables 1–11 were used to test Hypotheses 1–4 ($n = 333$); variables 12–18 were used to test Hypotheses 5–8 ($n = 90$).
[b] Correlations above the dotted line are significant ($p < .05$) at $r = .10$; correlations below the dotted line are significant ($p < .05$) at $r = .21$.
[c] This value represents tens of thousands of dollars.

RESULTS

Table 2 presents results from the probit analyses of the relationship between unit type and hiring and treatment practices.

These results support Hypothesis 1a, which predicts that hybrids will emphasize hiring professionals more than will drug abuse treatment units. The coefficient for drug abuse treatment units is significant and negative, indicating those units were less likely than hybrids to emphasize hiring professionals. The coefficient for mental health treatment units is not significant, indicating that there is no significant difference between hybrids and those units in their emphasis on hiring professionals. Hypothesis 1b predicts that hybrids will emphasize hiring ex-addicts more than mental health units. The results also support this hypothesis. Hybrids were more likely to emphasize hiring ex-addicts than mental health treatment units and did not differ from drug abuse treatment units in their emphasis on hiring ex-addicts.

The results in Table 2 do not support Hypothesis 2, which predicts that hybrids will not emphasize complete abstinence from drug use as much as drug abuse treatment units. Rather, hybrids were more likely than mental health treatment units to emphasize abstinence and did not differ from drug abuse treatment units on this goal.

The results provide only partial support for Hypothesis 3, which predicts that hybrids will use DSM-III more routinely than drug abuse treatment units. Although the latter was true, hybrids did not use DSM-III as routinely as mental health treatment units. Thus, the results concerning treatment practices suggest that hybrid units did not rely as heavily on the psychoso-

TABLE 2
Results of Probit Analyses[a]

	Hiring and Treatment Practices			
Predictors	**Reliance on Professionals**	**Reliance on Ex-addicts**	**Sobriety Goal**	**Use of DSM-III**
Unit type[b]				
Mental health treatment units	0.10	−0.75**	−0.77**	0.74**
Drug abuse treatment units	−0.47**	0.16	0.14	−1.06**
Percentage of drug abuse clients	.00	.00	.00	.00
χ^2	16.43**	18.26**	9.48*	59.90**
Variance explained	.32	.27	.65	.57

[a] One-tailed significance tests are used ($n = 333$).
[b] Hybrids were excluded; coefficients represent comparisons to hybrid units.
* $p < .05$
** $p < .01$

cial model as we hypothesized they would. The results also indicate that there was no significant relationship between the mix of clients that units were treating and their hiring and treatment practices.

Hypothesis 4 predicts that large, old hybrids would be more likely to hire professionals and use DSM-III routinely and less likely to emphasize abstinence as a treatment goal than younger and smaller hybrids. The results generally did not support this hypothesis. The only analysis with a significant overall chi-square value (8.14, $p < .05$) indicates that, as predicted, large hybrids were less likely to emphasize complete abstinence. But there was no significant association between reliance on professionals and hybrids' size and age ($\chi^2 = 3.63$, n.s.) or between reliance on ex-addicts and size and age ($\chi^2 = 5.00$, n.s.). Similarly, there was no significant relationship between hybrids' use of DSM-III and their size and age ($\chi^2 = .58$, n.s.). Finally, the results indicate that neither client mix nor director's experience were significantly related to either hybrids' hiring or treatment practices.

In sum, the data indicate that inconsistencies in hybrids' practices result in large part from their adopting a new treatment goal—abstinence—while retaining a traditional treatment practice, the use of DSM-III, and mixing hiring practices by hiring both professionals and ex-addicts. In other words, inconsistency occurs not because some hybrids abandon traditional practices completely while others do not but because hybrids generally mix practices from their traditional and new sectors. This is what we define as partial adaptation.

Table 3 presents results from multiple regression and probit analyses of the relationship between the isomorphism of hybrids with the mental health sector and support from their parent organizations. Table 4 presents results from probit and multiple regression analyses of the relationship between the isomorphism of hybrids with the mental health sector and support from other groups and organizations.

Hypothesis 5a predicts that the greater the isomorphism of hybrid units with the mental health sector, the more resource support they will receive from their parent organizations. The results provide substantial support for this hypothesis. Hybrids that tended to treat mental health rather than drug abuse clients, used DSM-III routinely to diagnose clients, and relied more on professionals than on ex-addicts received more resource support from their parents than hybrids that relied less on these practices. Hypothesis 5b predicted that the greater the isomorphism of hybrid units with the mental health sector, the more social-psychological support they will receive from their parent organizations. The results provide partial support for this hypothesis. To the extent that hybrids treated more mental health than drug abuse clients, their members received more social-psychological support from parent organizations.

Hypothesis 6 predicts that the greater the isomorphism of hybrid units with the mental health sector, the greater the number of three primary men-

TABLE 3
Relationship Between Unit Isomorphism and Parent Organization's Support

Predictors	Resource Support[a]	Social-Psychological Support[b]
Percentage of drug abuse clients	−.21*	−.01*
Use of DSM-III	.30**	.24
Sobriety goal	.01	−.14
Reliance on ex-addicts	−.28**	−.13
Reliance on professionals	.16†	.17
Director's experience	.11	.03
Unit age	.22*	−.02
Number of clients/number of full-time employee equivalents	.07	−.01
Number of clients	−.02	−.01*
Number of full-time employee equivalents	−.08	−.01
F	2.93**	
R^2	.28	
χ^2		18.67*
Variance explained		.06

[a] Standardized regression coefficients (n = 90) are reported; one-tailed significance tests are used.

[b] Probit coefficients are reported (n = 90); one-tailed significance tests are used.

† $p < .10$

* $p < .05$

** $p < .01$

tal health licenses they will hold. Table 4 provides substantial support for this hypothesis. Hybrids that used DSM-III routinely, did not emphasize hiring ex-addicts, and did not emphasize complete abstinence from drugs as a treatment goal had more mental health licenses than others.

Hypothesis 7 states that the greater the isomorphism of hybrids with the mental health sector, the larger their number of mental health sector financial sources. Results (see Table 4) provide partial support for this hypothesis. Hybrids that used DSM-III routinely had more such sources. In addition, old hybrids were supported by more mental health sector financial sources than young hybrids.

Finally, Hypothesis 8 predicts that the greater the isomorphism of hybrids with the mental health sector, the more financial support they would receive from mental health sources other than their parent organizations. The results provide partial support for this hypothesis. Hybrids that treated more mental health than drug abuse clients received more total funds from the mental health sector. Three control variables were also significantly related to the amount of money from mental health sector sources. Hybrids that had more experienced directors, were older, and had more full-time equivalent employees received more funds from the mental health sector.

TABLE 4
Relationship Between Unit Isomorphism and Support from the Mental Health Sector

Predictors	Number of Mental Health Sector Licenses[a]	Number of Mental Health Sector Financial Sources[a]	Total Mental Health Sector Financial Support[b]
Percentage of drug abuse clients	−.01	.00	−.30***
Use of DSM-III	.64*	.72**	.13
Sobriety goal	−.29**	−.05	.06
Reliance on ex-addicts	−.31**	−.11	−.02
Reliance on professionals	.05	.07	.02
Director's experience	−.01	.00	.20*
Unit age	.00	.04*	.17†
Number of clients/number of full-time employee equivalents	.00	.00	−.02
Number of clients	.00	.00	.15
Number of full-time employee equivalents	.00	−.02	.28**
F			3.68**
R^2			.33
χ^2	17.57*	13.74†	
Variance explained	.11	.14	

[a] Probit coefficients are reported (n = 90); one-tailed significance tests are used.

[b] Standardized regression coefficients (n = 77) are reported; one-tailed significance tests are used.

† $p < .10$
* $p < .05$
** $p < .01$

DISCUSSION

In the research reported here, we examined organizational units that, as a result of diversification, moved from an environment that presented relatively consistent demands to a fragmented environment that presented conflicting demands. We predicted that these units would adopt conflicting practices in response. We argued further that, because organizations have limited ability to meet environmental demands, they would respond selectively to conflicting demands; that is, they would adopt a few practices valued by external groups and thus attain a minimum level of legitimacy. Further, organizations will adopt practices that are visible to external groups so that conformity can be rewarded.

The results of this study provide partial support for our arguments. Hybrids, special treatment units resulting from mental health centers' diversification into drug abuse treatment, faced conflict between the psychosocial and the Alcoholics Anonymous (AA) models of drug abuse treatment. The results suggest that they responded by combining hiring practices from the mental health and drug abuse treatment sectors. Contrary to our hypothesis,

however, the results suggest that hybrid units also adopted conflicting goals for client treatment and somewhat inconsistent treatment practices.

These results are consistent with Meyer and Rowan's (1977) views on the adaptation of organizations to conflicting institutional demands. Further, the results provide little support for the view that organizational ability to change core features is limited and that organizational adaptation is contingent on task environments.

Another prediction was that hybrid units would receive more support from sources in their traditional sector, the mental health sector, the more they used mental health practices. The findings generally supported this proposition. Although the strength of relationships between hybrid isomorphism and external support varies with the source of external support and the aspect of isomorphism considered, our findings support the institutional theory view that environmental actors reward organizational isomorphism. Our results are also consistent with Hannan and Freeman's (1984) assertion that organizational inertia is rewarded and that change is risky. Units that continued to use mental health sector practices after they began to treat drug abuse clients had more external support than units that altered their routines to rely less on such practices. It is also important to note that, until recently, the mental health sector has had greater financial resources than the drug abuse sector (Vischi, Jones, Shank, & Lima, 1980). Thus, hybrid units that conform to mental health practices have an advantage in securing external support because they occupy a more munificent sector of the environment than hybrids that conform to the AA model.

The findings from this study should, however, be viewed with some caution. First, the amount of variance accounted for in several of the equations was modest. Second, this study used self-report data from two top managers to measure organization-wide beliefs and practices and measured many concepts with single Likert-scale items. Third, additional research is needed to discover the extent to which these findings can be extended to other populations of organizations.

The sample studied here consisted of small, young organizational units. On the one hand, such units may face fewer inertial forces than other organizations (Hannan & Freeman, 1984) and thus may find it easier to change established practices. On the other hand, it may be more difficult for small organizations to adopt or retain conflicting practices. For example, it is likely that the leaders and other members of the small units studied here will have detailed knowledge of any changes in treatment techniques that occur within them; these units are typically so small, with the equivalent of seven or eight full-time employees, that members have constant personal interaction. In large organizations, conflicting practices can be more easily decoupled from each other (Meyer & Rowan, 1977) because there is a greater capacity to separate the conflicting practices and parties in time and space. The inability of small organizations to decouple conflicting practices could make it easier for external groups to identify and punish deviation from their expectations.

Moreover, the sample consisted of organizations with strong institutional environments and weak technical environments (Alexander & Scott, 1984). Organizations operating in strong technical environments are rewarded for effective control of work production and thus are expected to focus attention on the coordination and control of technical processes. In contrast, mental health and drug abuse treatment organizations typically have not faced pressures for efficiency. Rather, they typically encounter strong institutional environments dominated by groups with deeply held beliefs about how treatment should be conducted. Treatment units may, however, face institutional demands of varying strength. For example, states vary in the extent to which they regulate and monitor mental health and drug abuse treatment services. Treatment units located in states with weak regulatory constraints may face relatively weak institutional environments.

Directions for Future Research

This study suggests several important directions for research that may enhance institutional theory. First, we argued that organizations will respond differently to institutional demands of varying strength and importance. In contrast, previous work has tended to assume that all institutional demands are equal in strength and importance. Much more work is needed to refine and measure the concept of hierarchies of institutional demands. This concept has a parallel in the work of Cook, Shortell, Conrad, and Morrisey (1983), who proposed that organizations establish a hierarchy of responses to external demands and rely first on responses that are the least costly in terms of resources and autonomy.

Second, more conceptual and empirical work is needed to map the variety and richness of institutional environments (cf. Powell, 1987; Scott & Meyer, 1983). Within some sectors or organizational fields, there may be clearly defined hierarchies of institutional pressures based on the salience of particular beliefs. In such sectors, organizational responses to institutional pressures may be relatively uniform and easily understood. In other sectors, however, institutional environments may be best characterized as free markets for beliefs, with several belief systems competing for attention and acceptance. Further, there may be no central authority or powerful group limiting competition among various beliefs. The responses of organizations to such institutional environments are little understood, but they are likely to be complex. The current research suggests that in such circumstances, organizations seek to combine important practices, even though they are conflicting.

Third, the results suggest that there may be some important differences in the ability of external actors to monitor and reward organizational isomorphism. Hybrids received more support from their parent organizations than from other organizations, particularly mental health licensing agencies, for conforming to mental health practices. Our interpretation of those results is that parent organizations have more ability to monitor hybrids than other mental health sector organizations. Parent organizations have physical prox-

imity to hybrids, which allows them to monitor hybrids' behavior at a relatively low cost. Moreover, parent organizations have the authority to monitor hybrids' behavior. Scott (1987) pointed out that actors in institutional environments can influence organizations by imposing practices on them, by authorizing the use of practices by exercising legitimate authority, and by inducing the use of practices with resources and rewards. In all those cases, organizations depend on external actors whose influence can be understood from a resource dependence perspective (Pfeffer & Salancik, 1978).

Our findings suggest, however, that resource dependence may be a necessary but not sufficient condition for conformity. Regardless of resource dependence, the ability of an external actor to monitor conformity will be an important factor in creating isomorphism. In turn, effective monitoring depends on proximity and on the frequency of monitoring attempts. The Joint Commission on the Accreditation of Health Care Organizations is, for example, a powerful actor in the institutional environment of hospitals and, increasingly, drug abuse and mental health treatment organizations. Yet this commission is located far from most of the organizations it monitors and only has the resources to check conformity to standards every three years. From an organization's perspective, superficial conformity may be sufficient when a powerful actor is located far away and its assessment of isomorphism is a rare ceremony rather than part of the organization's daily routine.

McCubbins and Schwartz (1984) argued that when state agencies monitored organizations through rare and predictable visits, they had less influence than agencies that conducted monitoring using a "fire-alarm method." In the latter approach, individuals and groups directly affected by an organization's performance are encouraged to contact state authorities when they detect violations of regulations. By involving consumers, fire-alarm monitoring can increase organizational surveillance. To take this approach, a regulator (a state mental health department, for example) would need to educate consumers and their families about how to evaluate the quality of drug abuse treatment they receive.

Finally, we have argued that organizations faced with new beliefs may be tempted to abandon or decrease use of practices traditionally rewarded in their institutional environment. This argument suggests that organizations and their managers sometimes make changes in their behavior that are risky even though they may be only superficial. Under what conditions will organizations make risky changes in their practices, even to the point of abandoning practices that are traditional in their institutional environments?

Such shifts may be particularly likely when (1) traditional practices are bureaucratically based, consisting of routines governed by a set of internally and externally imposed rules, (2) those rules have not been fully institutionalized and thus are not taken for granted as the most appropriate guides for behavior, (3) proponents of such rules do not have the power or means to enforce adherence to them, and (4) new practices are emotionally laden and ideologically appealing. Thus, we distinguish between elements of institutional environments that can be characterized primarily as rules, laws, and

regulations and elements that can be viewed as beliefs with strong emotional and ideological components (cf. Scott, 1987: 497–498). When faced with conflicting expectations about how they should behave, managers may be tempted to abandon rule-bound practices to adopt practices based on emotionally and ideologically compelling arguments.

In the present study, the AA model presented the managers of hybrid units with practices that not only conflicted with psychosocial approaches but also were promoted by groups with strong emotional and ideological drive. Advocates of the psychosocial model have nothing to match the widespread interest and affect generated by Pulitzer Prize winner Nan Robertson's (1988) best-seller *Getting Better: Inside Alcoholics Anonymous* or by the Emmy award–winning television film describing the birth of Alcoholics Anonymous, *My Name is Bill W.*, which was shown on a Sunday night during prime time. The motivation to conform to such beliefs and practices may be greater than the motivation to adhere to rule-based practices. We propose future closer study of the differences that may exist in organizations' conformity to practices in their institutional environments promoted primarily by rules and regulations and to practices promoted by emotionally and ideologically compelling actors and arguments.

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