

Participation In and Employee Attitude Toward  
Organizational Change: a Case Study of  
Strategic Change at George Pearson Centre

BY

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**ABSTRACT**

**Title:        Participation In and Attitude Toward  
                 Organizational Change: a Case Study of  
                 Strategic Change at George Pearson Centre.**

The British Columbia Rehabilitation Society (B.C. Rehab) recently approved a strategic plan which, when implemented, will change the organization's delivery of services to British Columbians with disabilities. In addition to a review of the literature to determine the factors influencing employees' participation in the strategic change process and their attitudes to it, this case study employs two primary methods of inquiry. Firstly, B.C. Rehab's strategy development process is identified and examined through perusal of B.C. Rehab documents. Secondly, a self-administered mail questionnaire surveys employees' attitudes toward the strategic change effort and their participation in the planning.

Results reveal that the organization followed a corporate planning model of strategic change; strategy formulation was accomplished through strategic planning. This method of strategy formation is consistent with B.C. Rehab's traditional structure and its apparent adherence to hierarchical authority. Results reveal differential opportunity to participate in strategic planning according to organizational role. Those in professional/management roles report greater opportunity to participate than those in non-professional designations. More impoverished understanding of the

strategic plan and weaker overall agreement with the organization's five strategic goals are reported by the non-professional group.

Employees' concerns about the strategic plan relate to feelings of uncertainty about their future with the organization. In addition to their prediction of its being the most difficult to implement, staff report a high degree of ambivalence to the goal to move to a "consumer-driven" framework. Respondents assess employees' overall attitude toward the strategic plan as ambivalent.

The results lend support to organizational models which encourage employee participation. However, it is concluded that several elements, including the organization's cultures, its structure and politics, interact to systematically pre-determine employees' participation in decision-making processes.

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N.M.C.

**DEDICATION**

To the memory of  
Walter John Clarke

## INTRODUCTION

George Pearson Centre is a 200-bed facility which provides long-term residential care for adults severely disabled by traumatic injury and debilitating disease. Operated originally by the provincial government as a hospital for tuberculosis and then polio patients, George Pearson Centre's governance was assumed by the British Columbia Rehabilitation Society (B.C. Rehab) in 1984. B.C. Rehab also operates the G.F. Strong Rehabilitation Centre which it has done since the Centre's inception in 1949.

Great technological advances, drastically changing demographic trends plus several socio-economic and political pressures prompted B.C. Rehab to examine its service delivery system and to plan for the future. In May, 1991, the organization began a formal process of developing a long-range plan. The process had actually commenced in the mid-1980s with a number of preparatory activities including an external environmental analysis, internal assessment of organizational strengths and needs, inception of organizational development programs and reformulation of the mission statement.

The formal planning process is referred to by B.C. Rehab as "strategic planning" and the results, the "strategic plan." Strategic planning differs from other forms of planning in that it involves "making strategic decisions about major plans for the organization" (Anthony, 1985, p.3). It differs, according to this author, "in importance, scope, resource commitment, time frame, and purpose" (p.3). Five key elements distinguish strategic planning

from other forms of planning:

It recognizes the outside environment and explicitly incorporates elements of it into the planning process.

It has a long-term time focus, often 3 to 5 years, but sometimes as many as 10 to 20 years.

It is conducted at the top of the organization and at the top of the organization's major divisions or product groups.

It involves making decisions that commit large amounts of organizational resources.

It sets the direction for the organization by focusing on the organization's identity and its place in a changing environment. (Anthony, 1985, p.4)

By definition, strategic change exacts significant impact on an organization's various, interdependent systems. The "top-down" approach of strategic planning reflects its roots in the hierarchically-structured military (Mercer, 1977). Strategic planning models were first adopted by "big business" in the 1960s. In the three decades since, strategic planning has been viewed by the private corporate sector as a necessary, if not integral, means of surviving and flourishing in an increasingly competitive global economy.

The economic and political realities which affect corporations have also had an impact on government-funded social service and health care organizations. In an attempt to respond to these and other external pressures, many non governmental or non-profit organizations have resorted to tactics previously the purview of the corporate sector. B.C. Rehab, like so many of its counterparts, has turned to strategic planning as a means of

identifying, planning for and dealing with future contingencies.

At the outset of formal planning, the organization articulated several philosophies intended to underpin the planning. Among them was the ideal that planning include input by staff at all levels and from all parts of the organization. Documents indicate that in excess of two hundred people, many of whom were staff of George Pearson Centre, participated directly in the planning process as members of various working groups or committees.

By definition, strategic planning models have traditionally excluded participation from those occupying positions in the lower levels of the organization's hierarchical structure. Lower-level participation has been considered cumbersome and inappropriate for the type of (substantive) change desired by organizations undertaking strategic planning.

It is widely recognized, however, that the successful implementation of a strategic plan is significantly impaired without the shared vision and a reasonable level of commitment by stakeholders, such as employees (Senge, 1991).

Despite its enduring popularity, many feel that strategic planning has yielded disappointing results, relative to the commitment of resources it demands. Some critics question the model's ability to effectively improve organizational performance (Pearson, 1990). Many proponents of strategic planning agree that the process has problems and identify many process issues as contributing to this malaise (Gray, 1986). The lack of stakeholder participation, however, is rarely identified by

proponents as an issue to be addressed.

From the criticisms of strategic planning models have emerged alternative models of strategy development, many of which espouse broad participation by stakeholders. Among the more recent approaches is the learning school of thought which is underpinned by the belief that in any organization there are many potential strategists, a resource which should be developed and tapped. Critics assert, however, that most organizations do not have the luxury of time needed to approach strategy from a decentralized perspective. Moreover, organizations often require strategic visions that are innovative and consolidated--more likely to emanate from a centralized approach than one of decentralized learning (Mintzberg, 1990).

Six months after B.C. Rehab had commenced strategic planning, five strategic goals were identified and adopted by the Board of Directors. One year later, June, 1992, the strategic plan was completed and Year I of implementation commenced.

The strategic plan generated considerable interest amongst staff--often a topic of discussion in formal and informal settings. After the strategic plan was set, the author had the opportunity to interact with staff about their perceptions of its content and process. It appeared that despite the formal policies to the contrary, employees had perceived the strategic planning process as having a "trickle down," rather than a "bubble up," orientation. It appeared that many staff were anxious about the plan, and its implications and felt alienated from the process.

From this experience, the author became interested in both the content of the plan, the process B.C. Rehab had used to derive it and possible explanations for what appeared to be resistance to the proposed strategic changes. Specifically, since employees would ultimately be responsible for implementing the plan, the author was curious about their role. Hence, the decision to research the subject and to use the research as the basis for a thesis.

By conducting a case study of the B.C. Rehab experience, the author hoped to ascertain George Pearson Centre employees' attitudes toward and concerns about the strategic plan. She wished to determine the process by which the plan was developed and to determine employees' perception of their involvement in the process. Finally, the author hoped to identify those systemic factors may have affected the strategic change experience.

The research project, which comprises the core of this thesis, was conducted at George Pearson Centre and utilized a self-administered mail questionnaire. Its purpose was to survey the attitude of the Centre's employees regarding the content and process of the strategic plan. The project addressed the following questions:

What are George Pearson Centre staff attitudes to the content of the strategic plan?

What are George Pearson Centre staff perceptions of their participation in the development of the strategic plan?

What are the staff-identified concerns regarding implementation?

What is the relationship between the staff's perception of participation and its attitude toward the strategic plan?

The author expected results to reveal a high degree of disagreement with the strategic goals, particularly the two goals describing changes to how services to the disabled community would be delivered (namely Goal #1 which promoted the idea of consumer-driven service delivery model and Goal #5 which proposed the organization's movement to community-based services.)

The researcher expected to find a high degree of participation in planning by management and professional staff but a low degree of participation by non-professional and support staff.

The researcher expected to find a relatively higher degree of agreement with the strategic goals for those who had participated in the plan and corresponding low agreement by those who had not participated in the plan.

The researcher expected to find three major areas of staff-identified concerns:

- (1) issues relating to job security
- (2) issues related to the future of George Pearson Centre residents and
- (3) issues related to the dissemination of reliable information about the progress and impact of the strategic plan.

In addition to the questionnaire, this case study of the B.C. Rehab strategic planning experience included a review of several B.C. Rehab documents, as well as library research. B.C. Rehab documents provided the basis for much of the first chapter of this thesis which discusses George Pearson Centre's history and its

response, over time, to changing technological, political and social trends. Additionally, the first chapter gives an overview of B.C. Rehab's strategic planning process and the plan's content.

The library research provided information which ultimately helped guide the design of the research project and identify salient issues and perspectives. The findings of the library research are included in the second chapter, the Literature Review.

The design and methodology of the research project are described in Chapter III while the fourth chapter discusses the content of the questionnaire and presents the survey findings.

The results of the survey, the literature review and the review of B.C. Rehab documents are integrated and interpreted in the Discussion, Chapter V. A short concluding piece, Chapter VI, briefly discusses outstanding issues and makes recommendations for future research.

## CHAPTER I - CONTEXTUAL OVERVIEW

The idea of organizational change is not a new concept to George Pearson Centre or its staff. As is apparent in the historical account included in this chapter, the Centre's current services and roles have evolved over the years in response to changing conditions.

Changing external conditions have prompted the current strategic change effort, as well. These antecedent conditions will be discussed in this chapter as will the organization's response to them.

### **HISTORICAL PERSPECTIVE**

In 1949, two years after the organization's inception, the Western Society for Physical Rehabilitation opened British Columbia's first free-standing rehabilitation facility, G.F. Strong Rehabilitation Centre. On April 1, 1984, the Society, later named the British Columbia Rehabilitation Society (B.C. Rehab), also assumed responsibility for the operation of the George Pearson Centre.

George Pearson Centre provides long term residential care for two hundred adults who, as a result of neuromuscular dysfunction and related disorders, experience severe physical disability and, therefore, require specialized assistance.

The Centre is distinguished from other long-term care facilities in the province by the relative youth of its residents and by its provision of therapeutic programs and services. In addition to nursing care, residents have access to, as appropriate: physiotherapy, hydrotherapy, occupational therapy, leisure-time services (recreational therapy), communications assistance (speech therapy), counselling (social worker, chaplain, sexual health clinician), in-house medical, dental, ophthalmology, psychiatry and podiatry services. Additionally, Pearson Centre offers outreach services to people with disabilities who reside in the community.

#### **HISTORY OF CHANGE AT GEORGE PEARSON CENTRE**

Since its inception, as a 264-bed tuberculosis hospital in 1952, George Pearson Centre has experienced many changes. As chronicled by B.C. Rehab (1992a), some were the result of internally-motivated influences and changing priorities. Most, however, were in response to external, environmental conditions.

The first of many externally-motivated changes occurred very early in the institution's history. In 1954, as a result of the development and increased availability of new anti-T.B. drugs, tuberculosis rates began to decline. However, in 1954 the province experienced

an outbreak of polio--with a high incidence of bulbar paralysis, which shuts down the breathing muscles and organs--(which) produced hundreds of new patients in the province. (B.C. Rehabilitation Society, 1992d, p.6)

Vancouver General Hospital could not meet the demand created by the

epidemic. In November, 1954, the provincial government decided to add a new wing to the Pearson Hospital to accommodate non-ambulatory polio patients who required specialized chronic respiratory care. The new wing, referred to as the Polio Pavilion, was completed in June, 1955, and polio patients were admitted to Pearson Hospital, marking the beginning of its service to people with physical disability.

With the decline of polio, Pearson Hospital's patient profile began to diversify to include patients with other respiratory diseases and patients with spinal injuries.

The Marpole Infirmary, originally built as a hotel in 1912, was converted by Vancouver General Hospital circa 1917 as a "home for incurables." In 1923, the provincial government assumed responsibility for its operation. The province also operated a similar facility, the Haney Infirmary. Both were extended-care institutions that provided residential services to frail and elderly people, as well as those with cerebral palsy, muscular dystrophy and other neuromuscular dysfunctions.

The physical conditions in both facilities were poor. This inspired the formation of the Marpole Women's Auxiliary whose goal was to assist the residents of both infirmaries. When conditions did not improve, the group began to pressure the provincial government to close the two institutions.

Concurrently, declining tuberculosis rates created empty beds at Pearson Hospital. In 1963 the provincial government decided to close both infirmaries and transfer residents to Pearson Hospital.

The transfer of residents was completed in 1965 with the result that Pearson Hospital's focus officially changed to "patients who can benefit from rehabilitation" (B.C. Rehab., 1992d, p.11). In response to the new focus, new staff were hired and trained, new programs and facilities planned.

The 1970s saw an increasing number of spinal cord injuries as a result of motor vehicle and recreational accidents. This trend was reflected in those admitted to Pearson Hospital. The technological advances made during this period accorded severely disabled people significantly more mobility than they previously enjoyed. The availability of electric wheelchairs, which could be operated by means of "sip and puff" air, and portable, positive-pressure ventilation drastically improved quality of life for many residents at George Pearson Hospital.

The technological revolution continued and, in fact, accelerated through the 1980s and into the 1990s.

Many wheelchairs are electronic, as well as electric. Personal computers with a plethora of input devices open up communication and learning to many who previously had little opportunity for either. (B.C. Rehabilitation Society, 1992d, p.13)

With technological advances came the potential for Pearson residents to experience greater independence and self-determination. Residents became increasingly vocal in advocating for their rights, precipitating several innovative developments. Two are particularly notable: development of community living options and formation of a residents' council.

With the assistance of the Canadian Paraplegic Association,

six young men with high lesion quadriplegia, four of whom were ventilator-dependent, moved from Pearson to a group apartment in the False Creek area of Vancouver. Creekview, as it was called, was "probably the first time anywhere that people with such severe disabilities had made such a move and achieved such independence." (B.C. Rehabilitation Society, 1992d, p.18) In January, 1992, seven additional ventilator-dependent residents left Pearson to take up residence at a new-developed co-operative apartment complex known as Noble House.

In July, 1992, the residents of George Pearson Centre formally organized a residents' council. The council provided a vehicle for communication. It provided a formal structure through which residents could file grievances, lobby for changes, provide input into the centre's policies and procedures. Additionally, it provided a structure for the centre's administration to communicate with residents.

On April 1, 1984, responsibility for the operation of George Pearson Hospital was transferred from the provincial government to the B.C. Rehabilitation Society (then known as the Western Rehabilitation Society.) George Pearson Hospital was the last of several provincial hospitals to be so transferred, reflecting the provincial government's policy to divest itself of direct responsibility for hospital operation.

Pearson's increasingly important rehabilitation component made the inclusion of G.F. Strong Rehabilitation Centre and George Pearson Hospital under one governance a sensible option.

Ultimately, the name, "George Pearson Hospital," changed to "George Pearson Centre," more adequately reflecting the institution's evolving philosophy and focus.

### **THE DECISION TO UNDERTAKE STRATEGIC PLANNING**

As it approached the 1990s, B.C. Rehab recognized that the organization was faced

with far-reaching changes on various fronts, both internal and external. External government policy and even social trends such as changing family values all have an impact on our consumers and on us as an organization. (B.C. Rehabilitation Society, 1992c, p.6)

In the mid-eighties, in response, the organization commissioned a consulting firm to conduct an environmental analysis. An assessment of internal strengths and needs was also conducted and several organizational development programs were instituted at both the G.F. Strong Centre and George Pearson Centre. In May, 1991, the organization officially embarked on a process of strategic planning (B.C. Rehabilitation, 1992c).

### **ANTECEDENT CONDITIONS**

A number of antecedent conditions prompted B.C. Rehab's decision to undertake external and internal assessments and ultimately to commit to strategic planning. Among them: changing

demographic trends, technological advances, shifting socio-economic conditions, changing government policy and increasing demands for accountability in health-care provision.

### Demographics

According to the Health and Activity Limitation Survey conducted by Statistics Canada, 28,475 of British Columbia's 394,265 disabled adults (age 25+), reside in institutional settings. Institutional settings include nursing homes and other long-term care facilities. The British Columbia figure is exceeded in absolute terms only by Ontario which supports nearly 38% of Canada's 3.3 million disabled citizens.

As it evident by Table 1 Disabled Adults Residing in Institutional Settings in British Columbia, 80% of those disabled people who are institutionalized are 65 years of age and older. This is consistent with trends in the general population. Currently, 8% of Canada's 65+ population and 39% of Canada's 85+ population is institutionalized. (Marshall, 1987)

Table 1		
DISABLED ADULTS RESIDING IN INSTITUTIONAL SETTINGS IN BRITISH COLUMBIA*		
AGE	N	PERCENT
Under 25 Years	850	2.9
25 - 34	1,750	5.9
35 - 44	1,110	3.8
45 - 54	840	2.9
55 - 64	1,330	4.5
65 - 74	2,920	9.9
75 - 84	9,885	33.7
85+	10,685	36.4

\*Source: Statistics Canada  
Health and Activity Limitation Survey  
1991

It has been suggested that "Canada has recently joined the ranks of the old nations or societies. . . those 65 and over exceed 7% of the population. (Havens, 1981, p.1). Many demographers, utilizing assumptions about fertility, mortality and migration, predict that the rate of growth of the Canadian population over 65 will be 46% by the year 2000 while rate of total population growth will be less than 10% in the same period (Havens, 1981). Others suggest that while the absolute numbers of those under age 45 will remain relatively constant, the number of people aged 65 years and over will more than double by 2021 (Evans, 1985).

1981 figures indicate that life expectancy for women increased from 1950 by 25% to 78.9 years; for men by approximately 10% to 71.9 years (Peron & Strohmenger, 1985). Although life expectancy is only one factor contributing to the increased average age, it has important implications for the long-term care system. Evidently, people with chronic diseases are being kept alive longer (National Council on Welfare, 1990). Consonant with this is the prediction that as a result of increased life expectancy, individuals will spend relatively more time in a disabled state (Culyer, 1988). More people will utilize extended care services and facilities for longer periods.

A 1984 study of the impact of demographic change of the health care system suggested that Canada has one of the highest rates of institutionalization of its elderly in the world (Woods Gordon, 1984). Given Canada's apparent demographic transition, a significant increase in long-term care usage can be anticipated. Should patterns of health care provision remain unchanged, the anticipated expenditures to the health care system will increase 75% by 2021 (Woods Gordon, 1984).

### Institutional Care Issues

In the 1991 report of the British Columbia Royal Commission on Health Care and Costs, chaired by Mr. Justice Peter D. Seaton, it was stated that "the commission views long term care. . . and other

assistance to the chronically ill, the frail or the disabled as one of the most critical elements in our health care system" (p.C-163). This document reveals an emerging trend towards maintaining, in the community, individuals who would previously have been institutionalized (Seaton, 1991).

The trend toward community living is a result, in part, of the community's changing values around the appropriateness of institutionalization (Forbes, Jackson & Kraus, 1987). It is also indicative of a perceived need to ensure cost effectiveness in the provision of health care services (Marshall, 1987).

The issues associated with institutional care of vulnerable populations are well documented (Goffman, 1961; Rosenfelt 1965; Wolfensberger, 1972; Menolascino, 1977; Nelson, 1978; Vladeck, 1980). Many people who live in institutions experience great losses as a result of their placement. These include loss of individuality, of privacy, former meaningful roles, control over living space and self-determination. Responses of hostility, depression, withdrawal and increased dependence, are often diagnosed and treated from a medical perspective. Individuals become defined by their disease and dysfunction (Kalish, 1979) and accept roles of disablement which are socially devalued (Sutherland, 1981). Within the traditional structure, institutionalized individuals are powerless. Powerlessness is further reinforced by the protective attitudes of caregivers who perceive residents as victims, unable to control their lives (Kari & Michels, 1991).

### Self-Advocacy Movement

Over the past few years, there has emerged an "uncompromising mood" among people with disabilities. Increasingly, people with disabilities have begun to see themselves as disabled, "not by the idiosyncrasies of (their) bodies but by a society which is not prepared to cater to (their) needs" (Sutherland, 1981, p.9). The disabled community has manifested a strong self-advocacy movement which has demanded that disabled individuals be in control of their environment and direct any service that they require. This demand hinges on the right to be treated as "able-bodied" and is perceived by those who are disabled as a "right, not a privilege" (Brisenden, 1986). This philosophy dictates that service must be provided in such a way as to empower people with disabilities to "remain in control of both the personal assistance. . . that they require, and the people who provide it" (Holdsworth, 1991, p.22).

### Consumerism

Users of social services have traditionally been referred to as "clients" or "patients" rather than "consumers." These terms reflect important philosophical distinctions. In its traditional usage, the term "client" has connoted dependency on the service provider (Perlman, 1975). In contrast, the use of the term "consumer" implies a power-base in which the individual exercises

his/her prerogative in acquiring and utilizing goods and services to satisfy needs.

As evidenced by the increased numbers of citizen advocacy organizations and lobby groups, there has been growing concern about protecting rights of consumers of social services (Perlman, 1975). Despite the discourse, however, there has been little progress in involving consumers of human-service institutions in the decisions that affect their welfare (Fawcett et al, 1982).

Most long-term care facilities are structured around a medical model of service (Kari & Michels, 1991). The subject of consumers' rights is of particular concern in these settings because, inherent in their practice model is a view of the consumer as a patient and the medical personnel as experts who, by virtue of their role, merit the greatest authority. Within this model, also referred to as the disease model, the resident and his/her family are less powerful and are ancillary to the medical roles (Kari & Michels, 1991).

### Issues of Health Care Provision in British Columbia

The British Columbia Royal Commission on Health Care and Costs (1991) received submissions from many sources who were critical of the current health care system as "insensitive to local and regional questions, inflexible in its programs and policies and unfair in its distribution of resources" (Seaton, 1991, p.B-35).

As a result, the Commission recommended that control of the health care system be decentralized to encourage

public accountability for the management of our health care resources; cost control through the efficient and effective use of resources; coordination and integration of professions, institutions and ministries; services which will serve local needs; access to services in or as near to an individual's home as is possible.  
(Seaton, 1991, p.B-36)

In supporting the ideology of decentralized service, the commission recommended that primary and secondary health services be offered in local communities and tertiary care be provided by the large institutions located in the Greater Vancouver Regional Health District. Tertiary care is defined as

care that requires highly specialized skills, technology and support services. Usually provided in facilities serving a large region or the province as a whole.  
(Seaton, 1991, p. E-13)

B.C. Rehab has been identified in the Seaton Report as one of the Lower Mainland agencies jointly responsible for setting provincial standards and consultation to the regions regarding delivery of service to people with disabilities.

## **STRATEGIC PLANNING PROCESS**

B.C. Rehab's strategic planning process is summarized in Table 2 Strategic Planning Process.

Table 2 STRATEGIC PLANNING PROCESS	
Planning Stage	Date
Environmental Analysis	mid-1980s
Internal Assessment	mid-1980s
Reformulation of Mission Statement	June, 1990
Strategic Planning Commences	May, 1991
Approval of 5 Strategic Goals	November, 1991
Examination of Organizational and Operational Implications	March, 1992
Implementation	June, 1992

### Mission Statement

The Society's mission statement was reformulated and ultimately adopted by the Board of Directors in June, 1990:

The mission of the British Columbia Rehabilitation Society is to provide a continuum of coordinated, interdisciplinary, consumer-driven rehabilitation services to enable persons with physical disabilities to develop and use knowledge, skills and attitudes necessary to reach their potential. (B.C. Rehabilitation Society, 1992c, p.18)

### Formal Planning

Prior to its commencing the formal planning process, the

organization established a Strategic Planning Department and seconded a senior manager to act as Strategic Planning Coordinator. Financial resources, support staff and office space were allocated to the newly-formed department, giving strategic planning a high profile within the organization. When senior managers began the formal process of formulating a strategic plan, they perceived the finished product as a prescription or framework to

make the best use of . . . energy and resources over the next decade. Certainly such a plan is necessary, coming as it does at the end of the International Decade of Disabled Persons, and at a time when our assumptions about what we do and how we do it are being challenged by many sectors of society. At the same time, we must implement any change within a framework of economic restraint and a demand for 'value.' (B.C. Rehabilitation Society, 1992c, p.1)

### Staff Participation

B.C. Rehab allotted itself fourteen months to complete the strategic planning process. B.C. Rehab documents report that in excess of two hundred people from within B.C. Rehab participated in the process. Their perspectives provided the foundation for the identification and analysis of the resulting five strategic goals.

There were three planning committees: a Board Planning Committee, a Management Planning Committee and a Senior Managers Implementation Planning Group. In addition, eighteen staff working-groups addressed strategic planning from specific

perspectives, including: Approaches to Service Delivery; Arthritis; Assistive Technology; Behaviour Management; Brain Injury; Children and Adolescents; Community Living; Education and Training; Other Neurological Disabilities; Pain Management; Palliative Care; Psycho-Social Rehabilitation; Research; Respiratory Services; Sexuality; Spinal Cord Injury; Stroke; Substance Abuse; Vocational Services.

### Planning Principles and Values

B.C. Rehab documents reveal a number of beliefs and values relating to the planning process. Firstly, the organization decreed that the plan must address itself to B.C. Rehab as a whole, not to two separate organizations (referring specifically to The G.F. Strong Centre and George Pearson Centre.) Secondly, that the planning process include ". . .participation by staff at all levels and in all parts of the organization. . . ." (B.C. Rehabilitation Society, 1992c, p.6). The third tenet was a recognition that the planning process must shape the needed physical and organizational structures as opposed to allowing the structure to dictate the plan. Fourthly, was the expressed perception of planning as a developmental process, "that will equip staff both to maintain a strategic vision and to take on planning as an ongoing function of line management. . . ." (B.C. Rehabilitation Society, 1992c, p.6). The fifth underpinning was the organization's commitment that

planning be grounded in "mutual respect, teamwork and a drive for continuous improvement" (B.C. Rehabilitation Society, 1992c, p.7).

### **STRATEGIC GOALS**

In November, 1991, the B.C. Rehab Board of Directors approved five strategic goals in response to current and anticipated demographic, economic and philosophical trends. The strategic goals, which are complementary and inter-related, are consistent with many of the recommendations of the British Columbia Royal Commission on Health Care and Costs (B.C. Rehabilitation Society, 1992c; Seaton, 1991). The five strategic goals:

- (1) B.C. Rehab will commit to a consumer-driven policy and practice framework in all aspects of our work
- (2) B.C. Rehab will pursue community partnership in planning, delivery, research and funding of rehabilitation services
- (3) B.C. Rehab will focus clinical activity on the rehabilitation of individuals with neurological disabilities
- (4) B.C. Rehab will become a provincial resource centre in rehabilitation education, research and technology
- (5) B.C. Rehab will become a resource centre for specialized community-based programs supporting people with disabilities. (B.C. Rehabilitation Society, 1992b, p.4)

## OPERATIONAL IMPLICATIONS

Phase II, examination of the organizational and operational implications of the five strategic goals by senior management, was completed by March, 1992. The findings of this second phase were outlined in a discussion document called Formulating the Strategic Plan, which was distributed to participants and other stakeholders. In addition to a discussion of the plan's implications, the document also included an outline of planning tasks and a schedule of projected time lines.

Implementation of the strategic plan has major implications for the consumers, staff and the community. Some anticipated changes include:

- (1) Eventual merging of G.F.Strong and George Pearson Centre to one site, probably at the George Pearson Centre site.
- (2) Organizational restructuring with two main components: movement towards one organizational structure (as opposed to the current situation of two separate entities) and adoption of a "Program Model" with its more lateral structure
- (3) movement from a primary to a tertiary service delivery model with greater emphasis on provision of decentralized rehabilitation services (closer to home); B.C. Rehab to become a resource to other communities. Primary care to be provided by B.C. Rehab for only those individuals requiring specialized intervention.
- (4) focusing of developmental resources on rehabilitation

activities related to neuromuscular disability; corroboration and planning with community agencies providing rehabilitation programs and services to populations outside of the "neurological disability" classification

- (5) visible participation of consumers in all systems supporting and providing rehabilitation; increasing accountability to and evaluation by consumers (B.C. Rehabilitation Society, 1992a).

## **IMPLEMENTATION**

Following the time frame set during strategic planning, the third phase of the process, implementation, commenced in the year 1992/93. Year I was considered the "developmental stage where key concepts are . . . confirmed, resources identified, individuals, systems and funds committed and benchmarks identified" (B.C. Rehabilitation Society, 1992c). The primary goal of Year I of implementation (1992/93) was development of the organization's capacity to progress towards the strategic goals. With organizational development as an objective, the Management Committee established a number of priorities to be addressed in the plan's first year:

1. Develop an operational definition of 'consumer-driven' so that we can agree on the goal and evaluate our progress.
2. Establish an internal communication process which will ensure that our staff are kept well informed at all stages of our development.

3. Encourage both formal and informal cross-Centre communication at all levels and begin to inventory and integrate systems, resources and services.
4. Establish a public profile in the community and ensure a process of ongoing communication and consumer involvement.
5. Training and involvement of the key personnel needed to undertake the development envisioned.
6. Adoption of a Program Model of organization.
7. Encouraging, initiating, and implementing activities in the three identified areas: facility-based services, research and education and technology, and community-based programs.
8. Undertaking the major collaborative planning activities in Children and Adolescent Services, Arthritis and Orthopaedics/Trauma. (B.C. Rehab, 1992c, p.40)

## CHAPTER II - LITERATURE REVIEW

The primary purpose of this chapter is to identify the issues relevant to an examination of strategic change. Secondly, its purpose is to discuss the findings and conclusions of scholars whom have studied this subject area. In so doing, this chapter defines the tenets which framed this case study.

A review of the literature begins with a discussion of conditions antecedent to change in organizations and is followed by a discussion of change in human service organizations. A number of organizational change perspectives are identified and discussed and the models of community work which traditionally underpin organizational change episodes are outlined. The nature and function of strategic change is then described and perspectives on strategy development are discussed. This discussion focuses primarily on strategic planning and the learning perspective, giving particular attention to employee participation. The role of organizational structure, organizational culture and politics are examined as they relate to substantive organizational change efforts. This piece then concludes with a discussion of attitudes toward change, particularly employee attitudes toward strategic change.

## ORGANIZATIONAL RESPONSE TO ISSUES

An examination of the literature of the past three decades reveals a growing recognition that organizations operate within a very dynamic social-political-economic environment. Increasingly, these organizations are compelled by rapid environmental change to make appropriate adjustments, not only for the achievement of their respective mandates and goals, but for their very survival (Judson, 1991).

Organizations are faced with issues generated from within, as well as from outside their structures. Internally motivated pressures relate to organizational climate and leadership issues while external pressures relate to the market and include the organization's need to remain current and competitive in product line and services (Chandler, 1962; Cummings, 1980). A third motivator for organizational change, according to Beer (1980), is the pressure exerted by the community--consumer interest groups being one form; changes in government policies and regulations, another.

## NEED FOR CHANGE

Beginning in the 1980s, there emerged several trends which put into question the direction of human services delivery systems.

Kettner, Daley & Nichols (1985) identify four trends which have challenged the status quo. They include:

the increasing focus on the needs of special populations,  
the decline in the resources available for human service programs,

the increasing pressures for accountability in human services, and

the introduction of new techniques for both management and direct service personnel. (p.3)

### Increasing Focus of Needs of Special Populations

Warner (1977) argues that many human service programs have reinforced and sustained the subjugation of the very populations they claimed to serve. According to this author, many human service programs are not only ineffective but serve to further oppress recipients. Such programs refuse to acknowledge and address the systemic causes of the social issues and are, therefore, prepared only to treat symptoms, not causes. This author suggests that, in addition, human service programs systematically deny recipients access to decision-making--dictating solutions in a very paternalistic manner, without considering the wishes or opinions of the consumer group.

The insensitivity of some human services systems to recipients' needs and the oppression they engender has always been unacceptable to recipients. Individually, recipients have been

powerless to effect changes. However, as organized groups they have political, economic and legal power to advocate their special interests and to influence how social services are conceptualized, designed and delivered (Kettner et al., 1985).

Interest groups have organized and advocated around a number of issues and needs relating to age, race, class, gender, sexual preference and disability. As a result, human services organizations are becoming increasingly aware of the need to fashion themselves to fit the needs of their target population.

### Declining Resources

Most human service programs depend on government funding for their survival. In the past decade, however, the federal government has introduced several initiatives to withdraw from its involvement in social expenditures. As a result, social programs, delivered provincially by government institutions, private firms, non-profit societies and volunteer bodies have felt the negative repercussions (Hanvelt, 1992).

The current social policy climate is the result of an evolutionary process. Sustained by the economic growth of the postwar era (1950s and 1960s), social programs expanded. They began to crumble in the 1970s with the realization that the economic climate was "unsustainable" (Helco, 1981). Guest (1985) interprets this "reformulation" period as having resulted from a

loss of "political consensus" which had previously supported social programs:

this amounts to a crisis of faith in the welfare state. . . (which) paradoxically arrives at a time when the proportion of people needing its support is the largest since the Great Depression. (p.235)

According to Kettner et al (1985), commonly-held strategies for agencies dealing with the resultant funding cutbacks--reducing staff and cutting services back--do not address the real issues. The current climate challenges basic values and assumptions concerning the provision of social programs. Turem & Born (1983) warn that the survival of social programs and the agencies that provide them may well lay in the balance.

If human service agencies fail to get across their message that they provide necessary social benefits and if they persist in conducting business as usual in miniature, they may find out that it may soon be too late to prevent their demise. (p. 207)

### Increasing Pressures for Accountability in Human Services

In 1974, Tropp defined accountability as:

a legal obligation to account for the terms of a contracted transaction. These include obligations to the public, the agency, and the client to maximize effectiveness (measurable achievement of positive change as a result of planned intervention) and efficiency (optimum results for the lowest expenditure of resources, including time, money and energy). (as cited in Kettner et al., 1985, p.5)

The issue of accountability began to surface in the 1970s and continues to challenge human service organizations. No longer are human service programs able to justify their existence solely on the basis of their caring and benevolent attitudes towards their target populations. Along the same lines, the existence of human service programs cannot be considered evidence of a caring society and justified solely on that premise (York, 1982).

Taxes generate a major portion of human services funding. As a result of public contribution of tax and voluntary dollars to human service programs, three realities exist. Firstly, the financial support constitutes the public's sanctioning of such programs to meet socially accepted goals and objectives. Secondly, upon accepting public funding, human service programs imply agreement with sanctioned goals and objectives and accept the obligation to work within established parameters. Finally, the public trusts that in return for funding, programs will achieve desired outcomes and the funds will be used as efficiently as possible to this end (Kettner et al., 1985).

Carter (1983) suggests that agency accountability must address two issues. The first is that of efficiency. Efficiency refers to the number of units of output per resource. Effectiveness, the second issue, refers to the number of desired outcomes as a result of outputs. Essentially, the questions which must be answered are: Are programs achieving their goals and objectives? Is the public getting good value for dollars spent? In other words, are the programs worth it (York, 1982)?

## CHANGE IN HUMAN SERVICE ORGANIZATIONS

As evidenced by the rapid growth of social services in this century, Skidmore (1990) suggests that human services organizations have assumed an increasingly important role in mitigating the increasing stressors of the fast-paced modern western life.

Human services organizations function within the same socio-economic and political milieu as do business and other organizations. Like their for-profit counterparts, social service organizations are susceptible to changes in their environment.

Ideally, provision of social services should be driven by client need. To most effectively serve their clients, human service organizations, then, must be prepared to assess and respond to changing needs and conditions. However, research has indicated that without pressure to do so, organizations generally resist changes to the status quo (Greiner, 1967). Despite the fact that in human services, "clients' problems and needs are constantly changing, many social services agencies, similar to other organizations, are reluctant to change. Kettner et al (1985) propose that, to the detriment of their target populations, few human services organizations have been designed to readily accommodate revisions to the status quo. According to these authors, such

services . . .take on a life of their own, and the needs of individuals and special populations may not be recognized or understood. When delivery systems become fixed and inflexible, the emphasis shifts from meeting

clients' needs to surviving as an organization and to fitting potential clients into the services offered by the agency. The match between needs and services deteriorates. (p.2)

## ORGANIZATIONAL CHANGE PERSPECTIVES

Far from its being perceived as a naturally-occurring process, organizational change is viewed by many writers as a calculated and deliberate response to changing internal and external environmental conditions. In her 1980 work, Huff, advances the argument that organizations are political entities--microcosms of a broader political system. The external pressures that motivate them are power-based, as are the organizations' responses.

Huff (1980) also suggests that organizational responses are influenced by internal power-based conflicts. She suggests that, often, decisions are made or alternative options chosen, not on the basis of their intrinsic merits but on the basis of their advocates. Similarly, the timing of decisions is attributed to the influence of special interests within the organization, as well as to the requirements of the task. Huff's political paradigm supports the view that planned change can be initiated at all organizational levels.

Rothman and Tropman appear to support this thesis in their 1987 work. While they do not specifically address the role of intra-organizational politics, their writing appears to support the

concept of organizational change as an issue of power relations. They identify essentially three community work models which have had a significant impact purposive change experiences in the past quarter century. Each of these approaches--locality development, social planning and social action--describes organizational change from a different power perspective.

### Locality Development Model

The locality development model came to prominence in the 60s, 70s and 80s. Underpinning locality development is the belief that change is optimal when there is meaningful participation of a wide cross-section of people comprising the defined community. Central to this method, which is utilized in community development initiatives, is its heavy use of "democratic procedures, voluntary co-operation, self-help, development of indigenous leadership and educational objectives" (Dunham, 1963 as quoted in Rothman & Tropman, 1987, p.5).

### Social Planning Model

Whereas the locality development model underscores the value of broad-spectrum stakeholder participation, the social planning approach maximizes technical expertise of professional planners to

guide the deliberate, substantive change processes of complex bureaucracies. Unlike the locality model, the social planning model is not so concerned with community building or fostering social change. Rather, its "concern. . . is with establishing, arranging, and delivering goods and services to people who need them" (Rothman & Tropman, 1987, p.6). The strength of the social planning model, according to proponents, is in its ability to attend, firstly, to the design of social plans and policies and, secondly, to their cost-effective implementation.

### Social Action Model

The social action model

presupposes a disadvantaged segment of the population that needs to be organized . . . in order to make adequate demands of the larger community for increased resources or treatment more in accordance with social justice or democracy. (Rothman & Tropman, 1987, p.6)

Examples of such movements include consumer and environmental protection groups, civil rights groups and groups dedicated to ensuring the rights of people with disability. Social activists often seek "redistribution of power, resources and/or decision-making in community and/or changing basic policies of formal organizations" (Rothman & Tropman, 1987, p.6). Historically, this model has been used extensively to advocate for social change. Although it does not currently enjoy its former popularity, aspects of this model are still selectively used in community change

episodes.

In their 1985 work, Kettner et al suggest that organizational change can be achieved through several approaches. The approach chosen depends somewhat of the type of change desired. When comprehensive, long range change is desired, it often becomes the purview of boards of directors and high-ranking administrative officials and is addressed from the policy level.

Whereas policies provide the framework for service delivery, programs are the permanent structures through which an organization's articulated goals and objectives are achieved, through which human service organizations meet perceived client needs. Therefore, change in organizational policy is often reflected in and manifested by program change.

It is the contention of Kettner et al (1985) that traditional models of planned change such as the "problem-solving" model are no longer adequate. For organizations to flourish, they must be able to anticipate needs and plan for services. Models of planned organizational change must, therefore, incorporate an anticipatory element. To this end, these authors propose a change model which comprises five components: considering antecedent conditions, preparing for change, planning, implementing change and assessing change residue.

### **STRATEGIC CHANGE**

The non-incremental, substantive nature of strategic change

distinguishes it from most other forms of planned change. This is depicted in Tichy's (1983) definition of strategic change as,

non routine, nonincremental, and discontinuous change which alters the overall orientation of the organization and/or components of the organization. (p.17)

By definition and intention, strategic change is designed to produce substantial organizational innovation which it accomplishes by addressing the issues of organizational goals, objectives and policies (Webster & Wylie, 1988; Turton, 1991).

Change originating from upper-level bureaucratic positions is more likely to be comprehensive, involve more risk and cause more uncertainty than change decisions proposed by lower-level, less powerful bureaucrats. As Turton (1991) observes, "the nature of the problems confronting decision-makers is a function of their location in the organizational hierarchy (p.198).

Likewise, this author states, there is a relationship between the complexity of strategic change, its duration and the degree of uncertainty it produces.

The longer the timescale, the greater the complexity and the likely degree of uncertainty that will be experienced. (Turton, 1991, p.198)

The uncertainty, which accompanies substantive change, poses a considerable threat even to those occupying the senior positions in the organizational hierarchy. Strategic change is, therefore, resisted in many organizations. As one author observes,

because of their familiarity, older options are usually

perceived as having lower risks (or potential costs) than newer alternatives. (Quinn as quoted in Turton, 1991, p.196)

Change which emanates from lower-level positions is more likely to be incremental, partly because lower-level change agents must often mobilize "coalitions" within the organization to support their desired change. Large changes at these levels are, therefore, often resisted in favour of smaller ones (Cyert and March, 1963).

## **STRATEGIC PLANNING**

Planning, as a means of strategy formulation, came to prominence in the 1960s and is considered by many to be an effective approach, particularly for multi-business firms. It has enjoyed considerable professional and academic attention and has been lauded as an essential aspect of contemporary organizational life.

There has been considerable confusion in the terminology related to strategic planning (Pearson, 1990). In the literature, the phrase, "strategic planning" is often used generically to describe strategy formation through planning. However, Schaffer (1967) depicts "strategic planning" as one aspect or stage of "corporate planning," which he describes as

that collection of methods, departments, functions, tools, and activities which companies buy or create to help assure their future. . . . (p.158)

According to Schaffer's framework, the corporate planning process includes research, formulation of objectives, strategic planning and operational planning. Schaffer's first step is identification of corporate strengths and weaknesses and identification of opportunities and risks created by external or environmental trends. From this information, objectives are defined--the organization's future role (what it should become) is identified. Once goals and objectives are identified, the third element, strategic planning, commences. Its function is to formulate strategy or establish an "overall framework outlining how the corporation will move to its ultimate objectives" (Skidmore, 1990, p.69). According to Schaffer's model, once strategic planning is accomplished, implementation procedures (how each department will carry out the strategic plans) are established.

Despite its persistent popularity, strategic planning has often been disappointing in its impact on organizational effectiveness. This perception has prompted considerable research. However, there is a dearth of inquiry into the impact of this perspective's adherence to a relatively centralized, non-participative style (Camillus, 1980). In fact, Ensign & Adler (1985) scanned 300,000 records in a leading business database (ABI/INFORM) to arrive at 500 articles which comprise their anthology of contemporary viewpoints on strategic planning. It is very telling that this anthology includes not one reference to participatory style as it relates to strategic planning.

In the literature, constructs such as enrolment, commitment and compliance are discussed only as they apply to managers. Full participation in strategic planning by those at lower levels of the organizational hierarchy is either not supported or not addressed. A notable exception is Mercer's 1991 work which supports a modified strategic planning model. Even so, this model includes stakeholders only at certain intervals in the planning process.

Strategic planning models often span the organizational hierarchy, each level with responsibility for a distinct type of strategy. Typically, however, the lowest organizational level that is systematically included in this process is the functional management level (Chakravarthy & Lorange, 1991)--this, despite the a wide consensus that the successful implementation of a strategic plan requires the shared vision and commitment/enrolment of stakeholders (Senge, 1991).

Ironically, as highly centralized planning approaches were taking a foot-hold in the 1960s, a number of authors, Argyris (1957), McGregor (1960) and Likert (1961) were conducting research which ultimately revealed positive correlations between participative management styles, quantity & quality of work performance and increased positive employee attitudes.

Blake and Mouton (1977) concurred. It was their thesis that implementation of change in organizations requires the concerted participation of the whole organization. They suggested that leaders must lead the change, not dictate change by virtue of their organizational rank. Employee

commitment comes from having a stake in the outcome of interdependent effort. . .the key is involvement and participation in working planning and execution. (Blake & Mouton, 1977, p.180)

More recent work supports these earlier conclusions. In his 1991 work, Whyte asserts that people are not passive beings but, to the contrary, are active agents who become strongly committed to goals and objectives they set or have had a part in setting for themselves. He concurs with Walton (1985) that one of the elements which separates authoritarian organizations from participatory organizations is the shift from control to participation. One of the attributes and great strengths of effectively organized participation programs is strong stakeholder "ownership of ideas." Whyte (1991) discusses this concept with respect to potential for organizational change. He suggests that stakeholders

are more likely to respond to ideas for which they have some sense of ownership. And that sense is more likely to arise for ideas they have had some part in developing than for ideas imposed on them. (p. 177)

### Learning Perspective

Stakeholder participation is a central tenet in more recent approaches to strategic thinking. In his 1990 work, Mintzberg examines one such approach, which he coins the "learning school of thought."

The learning perspective approaches strategy development from

an organizational or collective point of view. Whereas the strategic planning perspective views the Chief Executive Officer (C.E.O.) as the main component, this perspective recognizes the talent of the collective. Underpinning this perspective is the belief that in any organization, there are many potential strategists, a resource which should be developed and tapped. According to this perspective, for collective learning to occur, retrospective thinking must be encouraged. The development of strategy in response to various external pressures and events must take root at all levels of the organization. The leader's role is not to envisage strategies (as in the planning models) but to manage a process of strategic learning within the organization. This perspective supports the idea of "emergent strategy" and suggests that

strategy making must. . .take the form of a process of learning over time, in which, at the limit, formulation and implementation become indistinguishable.

While the leader must learn too and sometimes (is) the sole learner, more commonly it is the collective system that learns;

. . .learning proceeds in emergent fashion through behavior that stimulates thinking retrospectively, so that sense is made of action. . . strategic initiatives are taken by whoever has the capacity to learn and the resources to support that capacity. (Mintzberg, 1990, p.155)

Supporters of this perspective suggest that as the organization learns, its plans evolve from patterned responses (emulating past efforts) to innovative, prototypical stances. Critics suggest, however, that the learning approach is "anti-

strategic," that it leans toward incrementalism--"prefers constant nibbling to a good bite" and as a result, does not establish clear strategy (Mintzberg, 1990, p.155).

Staw (1976), opposes the learning approach. He suggests that organizations committing to it often find themselves enticed into unintended circumstances, having been drawn, through incrementalism, into "escalating commitment." It has also been suggested that the learning perspective encourages disjointedness, thereby reducing organizational effectiveness.

With many actors free to choose, independent of strong central direction, the organization may continually bounce back and forth between competing perspectives promoted by different groups. Of course the opposite danger can be present too--that one perspective may win not because it is better but because its proponents are better politicians or champions. (Staw, 1976, p.27)

The stakeholder participation advocated by the learning perspective is further criticized as a cumbersome way to deal with strategic change notably when major commitments are required (Makridakis et al., 1982 as cited in Mintzberg, 1990).

It has been pointed out that organizations in crisis may not have the luxury of time needed to approach strategy from a decentralized perspective. Similarly, Mintzberg (1978) suggests that even when not in crisis, organizations often require strategic visions that are innovative and consolidated--more likely to emanate from a centralized approach than one of decentralized learning. The final criticism of this perspective relates to its cost. Critics suggest that the learning approach demands

considerable time and often results in "false starts" which are costly in terms of time, money and human resources.

Despite its limitations, the learning school approach has made a significant impact. It most commonly finds support in professional bureaucracies and in other organizations during periods of dramatic or unprecedented change or strategic change events which evolve due to the need for political manoeuvring (Mintzberg, 1983).

#### **INFLUENCES ON THE IMPLEMENTATION OF STRATEGIC CHANGE**

The literature speaks to a number of issues which have an impact on strategic change. Four, in particular, are worthy of further discussion: the nature of an organization's formal structure, organizational culture, organizational politics and employee attitudes.

##### **Formal Organizational Structure**

In their 1961 work, Burns and Stalker examine organizational response to changing environmental conditions. They conclude that not all organizations have the same capacity for change. Those organizations which fail to change or to innovate are, typically, those which demand obedience and employee loyalty and operate with a clearly defined hierarchy of control. In these organizations,

coined "mechanistic organizations," communication is usually vertical with the knowledge-base situated exclusively at the top of the hierarchy.

Conversely, organizations that are effective innovators, able to cope and thrive in new and unfamiliar situations, are those whose system of communications flows in both directions. These "organic organizations" enjoy a high degree of commitment to organizational goals and are distinguished by a leadership style which is leadership by expertise. That is, leadership is not determined by virtue of hierarchical status but is determined according to who has the most expertise to offer the issue(s) at hand.

In his 1987 work, Harrison suggests that organic organizations or systems, "encourage creativity and innovativeness, and facilitate rapid, flexible responses to change" (p.84).

Further, this author suggests, organic systems help organizations adapt to

uncertainties stemming from poorly understood and changing technological conditions and from unpredictable environmental conditions--such as markets subject to sudden changes of taste and unstable financial conditions. (p.84)

However, such systems are more costly and more difficult to administer. Hence, when environmental conditions are stable and predictable, organizations often choose the top-down orientation of mechanistic systems for their relative efficiency and ease.

Mintzberg (1983) and Walton (1985) concur with the early findings of Burns and Stalker that organizations differ in their

ability to successfully implement change. In this regard, Walton, too, delineates bureaucracies according to their power structure. Essentially he classifies organizations as adhering to one of two structures: a traditional approach based on imposing control or an approach which is based on eliciting commitment.

Traditional or "control-oriented" approaches provide little opportunity for employee input. At the heart of an organization invested in a control orientation is its desire to "establish order, exercise control and achieve efficiency in the application of the work force" (Walton, 1985, p.77). This model, a remnant of Frederick W. Taylor's turn-of-the-century views, promotes the partialization of the organization's "work" into small fixed tasks for which individuals can be held accountable. Job descriptions outline acceptable standards of performance but are orientated to "lowest common denominator" assumptions about workers' skill and motivational levels. According to Walton, massive hierarchical structures of top-down authority prevail over these organizations to provide order and to monitor and control as an assumed low-calibre workforce.

Recently, however, changing expectations among workers have prompted a growing disillusionment with traditional control mechanisms. Concurrently, growing global competition has rendered this approach obsolete.

A model that assumes low employee commitment and that is designed to produce reliable if not outstanding performance simply cannot match the standards of excellence set by world-class competitors. . . market success depends on a superior level of performance, a level that, in turn, requires the deep commitment, not

merely the obedience . . . of workers. (Walton, 1985, p.79)

Realizing that needed employee commitment will not be realized within traditional control structures, a growing number of organizations have begun to develop and adopt strategies to move away from these structures. Strategies are numerous but have included removal of hierarchies, increasing managerial spans of control, integration of quality and production activities at lower organizational levels, creation of broader-based jobs that involve greater responsibility and more flexibility and development of systems to encourage participation by all employees. As Walton (1985) suggests, these policies are often underpinned by a written statement of philosophy which "acknowledges the legitimate claims of the company's multiple stakeholders--owners, employees, customers, and the public" (p.80).

Mintzberg's 1983 work, followed in 1990 by Pearson's also found support for the thesis that organizational structure is a determinant of an organization's facility for change. Their work focused on the impact of power-relations and leadership style within bureaucratic structures.

Simple organizational structures, according to Pearson (1990) demand little standardized or formalized behaviour and are not heavily invested in planning or training. Because these (often young) organizations are run by direct supervision from the top, they are often flexible and can "outmanoeuvre" the more complex bureaucracies. With good entrepreneurial leadership, such

organizations are able to respond innovatively and quickly to change. However, only a few such organizations "retain their simplicity as large organizations" (Pearson, 1990, p.159).

In contrast are the well-established organizations which require large numbers of highly specialized, low skill jobs to undertake large-scale production. Mintzberg's characterization of these "machine bureaucracies" approximates the mechanistic organizations described by Burns & Stalker (1961). Machine bureaucracies are rigidly departmentalized, support a large-scale middle management hierarchy and are highly invested in maintaining systems of standardization. Such organizations, according to Mintzberg (1983), need a stable environment in which to function. For this reason, they search out such setting. Also characteristic, is "alienated employees, an obsession with control and an inability to adapt" (p.12). Mintzberg's characterization is supported by Pearson (1990) who concludes that bureaucratic structures brandishing these characteristics are fundamentally unsuited to innovation and are increasingly perceived as ineffective in meeting contemporary needs for flexibility and speed of response.

Mintzberg (1983) suggests there is a second bureaucratic structure the "professional bureaucracy." Whereas the machine bureaucracy relies on standardization of organizational processes and products, the professional bureaucracy relies on the standardization of skills of trained professionals. Professional bureaucracies yield much of their power to professional employees

and their professional associations. Mintzberg (1983) observes, however, that although the systems within professional bureaucracies are highly decentralized and participatory for the professionals, themselves, the structures are equally non-participative and autocratic for the numerous support staff who perform roles and functions discarded by the professionals. These groups, as a result, often experiences a sense powerlessness and alienation.

The situation of long-term care nursing aides is forwarded by Vladeck (1980) and Tellis-Nayak et al (1989), as an example of this phenomenon. This group, which occupies the low-end of organizations' hierarchical structure constitutes 70% of long-term care personnel and generally has the most direct contact with residents. Despite incumbent first-hand knowledge of residents, however, this group has traditionally had little influence in planning, setting policy and decision-making. Yet, when care issues arise, this group is often targeted for criticism. There is little recognition of the often-conflicting expectations of various players within the system and the resulting ambiguity in which this group must function without the power to change or influence practice. As a result, this group experiences low morale, low-level commitment to the organization and a high turnover rate.

As opposed to individual performance issues, these problems are symptomatic of organization-level issues. Harrison (1987) maintains that they are symptoms of "poor fit" between the organization's power structure or its administrative system and the

organization's overall environment, technology and personnel. Issues associated with organizational climate are very damaging to the organization. The resulting conflicts divert energy away from organizational goals and objectives and reduce the organization's effectiveness. They impair intra-organizational communication, reduce the organization's ability to be innovative and to cope with changing market or technical conditions and interfere with its ability to carry out complex projects. (Harrison, 1987)

### Organizational Politics

According to Pfeffer (1981a), organizational politics

involves those activities taken within organizations to acquire, develop, and use power and other resources to obtain one's preferred outcomes in a situation in which there is uncertainty or dissensus [sic] about choices. (p.7)

Often, "preferred outcomes" are driven by self-interest and the influencing of decisions is a means to align these self-interests with organizational interests (Culbert and McDonough, 1980). This process is not sanctioned by the organization and, in fact, is often counter-productive to organizational goals and objectives, used often as a tool of resistance. Mayes and Allen (1977) focus on the illegitimacy of both the means and the end in their depiction of organizational politics as the

management of influence to obtain ends not sanctioned by the organization or to obtain sanctioned ends through non-sanctioned influence means. (p.675)

During episodes of strategic change, the organization experiences shifts in power. Conflicts often arise, especially in mature, complex organizations of experts (Mintzberg, 1990). The impact of micro-political struggles (within the organization) are particularly felt

during periods of blockage, when strategic change cannot take place, often because of political intransigence, and periods of flux, when an organization is unable to establish any clear direction and so decision-making tends to take the form of a free-for-all. (Mintzberg, 1990, p. 165)

### Organizational Culture

Although micro political action is used to resist change, many believe that a more powerful source of resistance is organizational culture.

Many definitions of culture exist but Schein's (1985) definition is the most comprehensive:

A pattern of basic assumptions--invented, discovered or developed by a given group as it learns to cope with its problems of external adaptation & internal integration--that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think and feel in relation to those problems. (Schein, 1985, p.9)

Organizational culture is powerful, not only because of its dynamic nature but by virtue of its pervasiveness. It not only serves to form the attitudes and behaviours of the organization's

members, it is itself a result of organizational behaviour and attitudes. Scholz (1986) describes it as "the implicit consciousness of an organization which develops out of its members' behaviour, and which influences their behaviour" (p.235).

Much of the impact of organizational culture results from the fact that much of it operates at a preconscious level and is taken for granted. Schein (1980) demonstrates this dynamic aspect by his delineation of culture into three levels. He suggests that the most visible representations of organizational culture are the organization's artifacts, technologies, art and behaviour. While this level is the most visible, it is often difficult to interpret. The second, less visible level of organizational culture is comprised of the organization's values--testable in the physical environment and by social consensus. The third level is comprised of the organization's basic assumptions and addresses the organization's relationship to the environment. This level addresses the reality of time and space, human nature, human activity and human relationships. These, according to Schein, are the invisible aspects of any organization's culture which are so powerful because they are accepted without question by members.

Tichy (1983) suggests that as a system of influence, an organization's culture is both the most pervasive and the least obvious. Because it is implicit, people are not always aware of it in the same way they are of political dynamics and technical systems. As a result it is frequently overlooked in strategic change efforts. Even when it is identified as important, it is

often addressed only superficially. Tichy decries this as a fatal flaw. Organizational culture "is an essential condition of strategic change, requiring major attention and accounting for success or failure of a change effort" (Tichy, 1983, p.282).

Pfeffer (1981) suggests that the effective management of strategic change involves the successful linkage of political, cultural and technical systems. He argues that strategic change agents can only marginally influence the intra-organizational political system. They have slightly more potential to influence the organization's technical outcomes (quality and quantity of goods/services). Their most significant capability in strategic change efforts, however, is their potential to influence the organization's culture.

Much of the organizational literature has addressed culture as a tool for analyzing and understanding complex social organizations. It has been investigated as a key element in improving economic output and socializing organization members to management-defined values. Culture has been viewed as an avenue to organizational development processes and as a cognitive sense-making tool for organizational members in turbulent environments (Pedersen and Sorensen, 1988) Overall, much of the research portrays organizational culture as a monolithic entity and has implied a causal relationship between "strong cultures" and improved organizational performance. While Pedersen and Sorensen do not reject the idea of a dominant organizational culture, they feel it must be acknowledged that

organizations are often dominated by differentiation, inconsistency, ambiguity, conflict . . . .Instead of a dominant and cohesive culture, (some) organizations. . . could be characterized as consisting of different subcultures and lacking a significant corporate culture. (p.7)

Myerson and Martin (1987) suggest that in reasonably effective, multi-cultural organizations, the subcultures likely share elements of a dominant culture. The presence of different sub-cultures often produces conflict as members of the various sub-groups act on the basis of their internally consistent values, some of which may be inconsistent with those in other sub-cultures present in the organization.

### Employee Attitudes

Despite the fact that change is recognized as one of the inevitabilities of modern western life, it is perceived by many as a threat. Organizational changes often require stakeholders to modify the way in which they perform their duties. In fact, their change in behaviour, known as the operational effect, is often the primary purpose of the organizational change effort (Judson, 1991)

In addition to an operational effect, most change has a psychological impact on stakeholders. Often with good reason, impending changes trigger feelings of uncertainty and vulnerability. Stakeholders become concerned, to some degree, about their ability to learn (new roles) and to be competent in these roles. Performance, often directly connected to feelings of

self-worth, looms as an unknown quantity. As well, stakeholders are often concerned about being treated fairly, about the effect of impending changes on their status (and therefore, too, their personal worth).

Organizational change also alters the way that stakeholders interact with others in their network. Almost any change in work or work environment will tend to alter established, fulfilling and comfortable relationships with co-workers, managers and supervisors (Judson, 1991). Particularly at the outset of change, stakeholders are often concerned about the future of established work relationships.

Cultural factors play a large role in attitudes towards change. The organizational culture engenders in its members, certain beliefs and norms which enjoy universal acceptance within that culture. The development of a culture with its requisite behavioural norms and beliefs, enables individual members to express their own needs and tendencies. The beliefs and norms that take root serve to maintain equilibrium and continuity among the culture's members and are the effect of that organization's history, its experience with past leadership, its successes and failures (Judson, 1991).

Once established, any culture tends to influence the attitudes and behaviour of its members, particularly its more recent members, to conform to accepted beliefs and norms. Such cultural beliefs and behavioural norms are significant to any change effort, particularly when the real or imagined effects of change are in

conflict with them (Judson, 1991).

Although resistance to purposive organizational change may be affected by individual personality traits, the salient issue for many is that of loss of investment--investment in the status quo. "People's time, energy, and experience may all be considered to be investments, and any loss or reduction in their value may be felt as keenly as if actual money or property were involved." (Filley, House & Kerr, 1976, p.468) From this perspective, known as the "sunk cost" concept, proposed change may be perceived as devaluation of individuals' knowledge and experience and the endangerment, not only of their ability to make a living but, to the esteem attached to their career performance. Considering the implications, stakeholder resistance or opposition to proposed changes may be well-founded and rationally defensible (Warren, 1977).

Senge (1991) asserts that resistance to change

is neither capricious nor mysterious. It almost always arises from threats to traditional norms and ways of doing things. Often these norms are woven into the fabric of established power relations. The norm is entrenched because the distribution of authority and control is entrenched. (p.88)

Attitudes toward organizational change range from commitment and enrolment to apathy. It is suggested that enrolment implies free choice and is the process of "becoming part of something by choice" (Kiefer as quoted in Senge, 1991, p.218) Commitment, on the other hand, implies not only enrolment but, in addition, a sense of assuming full responsibility for making the vision

underlying the change happen. In most contemporary organizations, there are, however, relatively few people enrolled and even fewer committed. The great majority of stakeholders fall within a continuum of compliance--genuine compliance, formal compliance or grudging compliance. They go along with the vision and do what is expected of them to achieve it. Those genuinely complying see the benefits of the vision and do everything that is expected of them; those formally complying see the benefits of the vision but do only what is expected of them; those with grudging compliance do not see the benefits of the vision and do enough of what is expected to not risk losing their jobs (Senge, 1991).

It is often difficult to discern between those genuinely compliant and those who are enrolled or committed; compliance often being confused with enrolment or commitment. While those in genuine and formal compliance sincerely try to contribute, those in grudging compliance or noncompliance are distinguished by their "malicious obedience," often with the attitude of "I'll do it to prove it doesn't work" (Senge, 1991, p.220). While these individuals may not speak formally against the organization's goals (that is to the legitimate power figures), their opinions are expressed informally, for example at coffee breaks or other social gatherings of staff. Finally, according to Senge's model, are those who are apathetic, neither for nor against the vision. These individuals show no interest in and have no apparent energy for the plan.

Hardy (1992) identifies stakeholder resistance or opposition

to strategic change as the result of "poor process"--the ultimate "major crime" of strategic planning. He suggests that, as a result of poor process, "participants are turned off by the planning, (and) they often do not buy into the resulting plans" (p. 72). Arbitrary, top-down driven planning results in resistance by middle managers who actively or passively oppose attainment of the strategic goals. Of the two, states Hardy, passive resistance is the most insidious because it is so difficult to detect.

#### **ORGANIZATIONAL RESEARCH**

It is widely recognized that the latter part of this century has been a time of tremendous demographic, technological and economic change. If they are to survive, organizations must cope with resulting "gyrating markets, mushrooming technologies, and shifting political frontiers" (Strebel, 1992, p. vii).

#### **Employee Participation in Strategic Planning**

Many organizations have turned to strategic planning as a means of developing strategies to meet these challenges. Although strategic planning has received much professional and academic attention over the past three decades, there has been an very little research on the impact of participative style on strategic

planning. One of the few pieces of research conducted on this subject revealed a "negative relationship between broad participation-consensus strategies and major change outcome" (Webster & Wylie, 1988, p.42). The study's non-parametric design precluded its generalizability, but the data revealed incompatibility between full stakeholder participation and the goals of strategic planning--non-incremental, substantive change. However ungeneralizable these conclusions are empirically, they mirror an attitude prevalent in most strategic planning literature which supports exclusivity in the formulation of strategy.

### Centralization

Centralization is an important aspect of organizational effectiveness since the distribution of power affects the way an organization functions and the behaviour of its stakeholders (Miller, 1991). An economical and useful tool for measuring organizational participation is the Aiken and Hage Scale of Personal Participation in Decision Making and Hierarchy of Authority. It utilizes a Likert scale to measure "how much the individual participates in decisions about the allocation of resources and the determination of organizational policies" (Miller, 1991, p. 410).

### Target of Inquiry

Implementation of any planned change is characterized by a shifting in focus from planning and development to activation of the plan (Kettner et al., 1985). To identify problems or issues in the implementation of a program Posavac and Carey (1985) suggest that the target of inquiry should be "those who have a serious interest in the program and whose lives may potentially be affected by the program" (p. 31). There is concurrence that in such evaluations, the target group should appropriately include those who implement the program, the staff (Legge, 1984; Herman, Morris & Fitz-gibbon, 1987). Successful implementation of planned change necessarily requires the support and interaction of many players. Challenges to the status quo are not always well received as ". . . proposed changes may threaten existing territorial prerogatives or patterns of resource distribution. . ." (Kettner et al., 1985, p.216).

The perceived impact of organizational change on staff has received some research attention. Alpander and Gutmann (1974) examined the staff perceptions of an organizational change effort with respect to staff perceptions of organizational climate. The change included major restructuring of policies, procedures and working relationships within a psychiatric hospital. The research methodology included two questionnaires directed to direct-line staff and team leaders and face-to-face interviews of some of the respondents. The questionnaires addressed nine variables of

organizational climate. Subjects were also asked to assess the impact of the change on their own jobs and individual environment. The researchers concluded that resistance to change stems largely from fear of the unknown and that it can be reduced by providing employees with appropriate information. Further, these authors maintain that ". . . such communication can best take place if employees are included in some phases of the planning for change" (p.723).

#### Attitude Measurement

Attitude measures can be used effectively to communicate employees' feelings or reactions to major corporate change. According to Henerson, Morris & Fitz-gibbon (1978) measurement of attitudes is best accomplished through a direct, self-reporting approach, including self-administered questionnaires. The questionnaire survey has some general advantages in that the attitudes of many individuals can be canvassed at the same time, each respondent receives identical questions, the tool provides a vehicle for expression without respondent fear or embarrassment and interviewer bias can be avoided. Additionally, the uniform data facilitates long-range research applications. However, it must be noted that these measures have limitations. Because respondents strive for internal consistency, self-report response to one variable may be related to responses to previous variables

(Orlich, 1978). Rubin and Babbie (1989) suggest that the use of multiple measures and inclusion of qualitative and quantitative data, may assist in ameliorating the difficulties inherent in reliance on one measure. De Man (1988) goes one step further in suggesting that evaluation of organizational change is best served by research designs which generate qualitative data. In particular such designs are the most appropriate for situations where there is an underdevelopment of theory in the field of inquiry or when the phenomena involves processes about which the researcher hopes to gain contextual data.

### Research Questions

An examination of the employees' experience will assist in gaining insight into the strategic change processes at George Pearson Centre and answer the following research questions:

What are George Pearson Centre staff attitudes to the content of the strategic plan?

What are George Pearson Centre staff perceptions of their participation in the development of the strategic plan?

What is the relationship between the staff's perception of participation and its attitude toward the strategic plan?

What are staff-identified concerns regarding implementation?

**CHAPTER III - METHODOLOGY: GEORGE PEARSON CENTRE EMPLOYEE  
ATTITUDES TO STRATEGIC PLAN  
IMPLEMENTATION**

The purpose of this third chapter is to describe the methodology used to conduct the research project. The first section of the chapter begins with a definition of the research questions and is followed by a discussion of the research methodology. Issues such as appropriateness of the measure, sample selection procedures, reliability, validity, sample representativeness and data analysis are addressed.

**METHODOLOGY**

Employees play an integral role in the implementation of strategic change. It is imperative, as much as possible, to have their commitment to the planned changes. Without understanding and addressing their attitudes and concerns, successful implementation will be unpredictable and inefficient.

B.C. Rehab planning documents (1992) state that a number of the staff at George Pearson Centre, perhaps as a function of their position in the organization, participated in the strategic planning process. However, it appears that many staff did not participate directly.

As a result of these issues, the research project was designed to explore the following questions:

What are George Pearson Centre staff attitudes to the content of the strategic plan?

What are George Pearson Centre staff perceptions of their participation in the development of the strategic plan?

What is the relationship between the staff's perception of participation and its attitude toward the strategic plan?

What are staff-identified concerns regarding implementation?

In formulating the research methodology, it was important to be sensitive to the potential anxiety engendered by the strategic change plans. It was imperative that the research design take into account subjects' possible feelings of vulnerability and fear. The analysis and conclusions will be presented to B.C. Rehab and will assume a developmental format in order to allay potential fears of the results, and as partial compensation for the time expended by subjects.

### Subjects

George Pearson Centre has approximately 400 full-time and part-time employees. The sampling frame for this study included: all staff at George Pearson Centre except the Administrator, the Acting Director of Social Work, a fellow-student/social worker; and those who have worked a minimum of 500 hours at George Pearson Centre in the previous one-year period.

A total of 100 subjects were selected by a proportionate stratified random sampling method. With the assistance of the Acting Director of Social Work at Pearson Centre, the researcher utilized a list supplied by the Human Resources Department, which indicated all staff employed at George Pearson Centre as at February 1, 1993. The listed information included employee name, department and job title. Lists of auxiliary employees also included number of hours worked in previous twelve months.

The researcher reviewed the employee list to ensure each employee's eligibility according to the sampling frame definition. As eligible employees were identified, they were assigned consecutive numbers, commencing with number 100.

Using job titles as a guide, the researcher divided the total population into four groups according to role: direct care professionals, direct care non-professionals, management/supervisory, administrative/support staff. The number of employees in each group was counted; the total population in the sampling frame  $N=377$ . The ratio of each employee group to total number of eligible employees was calculated. Ratios for each of the four groups were used to calculate absolute proportionate numbers of subjects selected by the stratified random sampling method. Details are summarized in Table 3 Proportionate Sampling by Organizational Role.

**Table 3**

**PROPORTIONATE SAMPLING  
BY ORGANIZATIONAL ROLE**

ROLE	TOTAL POPULATION N=377		SAMPLE POPULATION N=100	
	N	Percent	N	Percent
DIRECT CARE NON-PROFESSIONAL	145	38	38	38
DIRECT CARE PROFESSIONAL	66	18	18	18
ADMINISTRATIVE/SUPPORT	121	32	32	32
MANAGERIAL/SUPERVISORY	<u>45</u>	<u>12</u>	<u>12</u>	<u>12</u>
Totals	377	100	100	100

Response Rate

In total, 47 of a possible 100 subjects responded, producing an overall response rate of 47%. The response rates are delineated according to organizational role in Table 4 Response Rates by Organizational Role.

Table 4 RESPONSE RATES BY ORGANIZATIONAL ROLE		
ROLE	N	Percent
Direct Care Non-Professional	16	42.1
Direct Care Professional	10	55.6
Administrative/Support	13	40.6
Managerial/Supervisory	<u>8</u>	66.7
Total	47	

It should be noted that five days after questionnaires were distributed to the sample population, George Pearson Centre staff commenced a 21-day strike--a coincidence which likely had some affect on the rate of return.

### Representativeness

The sample population appeared to be representative of the total population with two limitations noted. Firstly, the sampling frame included only those currently employed at George Pearson Centre. At the time of sample selection, implementation of the strategic plan had commenced and some staff restructuring was occurring. Some supervisors and managers had moved to G.F. Strong Centre or had left the employment of B.C. Rehab. Because of the sampling frame definition, the input of these individuals was not

solicited despite the fact that their opinions may have been quite insightful.

The second limitation relates to the fact that a large number of casual/relief workers (18%) constitute the staffing component although they do not affect the Full-Time Equivalents (F.T.E.) These employees are offered work on an "as and when needed" basis, providing relief for absent regular staff--vacations, illness and leaves of absence. Their employment status is quite difficult to ascertain since they are considered employees until such time as they refuse work opportunities. Seven incompletd questionnaires were returned to the researcher marked "no longer works here." Six were from administrative/support staff group; one was from the direct care non-professional group.

### Procedures

The Table of Random Digits (Hessler, 1992, p.329) was utilized to select a proportionate stratified random sample. The Direct Care Non-Professional group was selected first, the Direct Care Professional selected second, the Managerial/Supervisory staff group selected next, followed by the Administrative/Support Staff group. Selection commenced with the number in the fourth column, sixth line of the above-mentioned Table of Random Digits; the middle three digits of this random number were read and a number match in the appropriate grouping sought. When no match was found, the middle three numbers from the next number down the column were

considered and so on until selection of the first group was completed. The same procedure was followed for the second and third group.

As each subject was selected, his/her name, department (for mailing purposes) and matching number was placed on a master list. The master list was kept in a locked filing cabinet at the student researcher's home office. Each subject-number was placed on a checklist (Subject Tracking Checklist) to track date of initial letter, date of follow-up letter, date of return, etc.

Each group received the same questionnaire and each group was assigned a different colour to easily distinguish between groups. The direct care groups received pink questionnaires, the administrative/support group received yellow questionnaires and the managers/supervisory group received white questionnaires. Researcher originally intended to delineate all groups by using four different coloured questionnaires. However, due to a clerical error, a fourth colour was not printed. Therefore, to distinguish between professional and non-professional direct care staff, questionnaires directed to professional direct care staff were marked with an "x" in the bottom right-hand corner of the last page. Subject-number was recorded on the top right-hand corner of each questionnaire.

Sample selection was made on February 11, 1993. On that date, each subject was sent, through George Pearson Centre's internal mail system, an initial letter of introduction. On February 17 1993, the questionnaire and covering explanatory letter were

directed to each subject through the internal mail system. Included in the questionnaire package, was a self-addressed return envelope. Respondents were invited to place the completed questionnaire in the envelope provided and to return it to researcher either through the internal mail system or to place completed questionnaires in the researcher's mail basket in the social work department.

On Monday, February 22, 1993, five days after questionnaires were distributed, the staff at George Pearson Centre went on strike. They returned to work on Tuesday, March 16, 1993. On March 16, 1993, 21 completed questionnaires were collected from the mail basket. On March 17, 1993, each non-respondent was sent a second questionnaire, identical to the first, covered by an explanatory, follow-up letter. A second follow-up letter was sent to non-respondents on March 23, 1993.

The mail basket was cleared of questionnaires again on March 18, March 23 and March 26 and March 30, 1993. Questionnaires were date stamped when collected. The return of each completed questionnaire was noted on the Subject Tracking Checklist. Questionnaires were batched according to the stamped date. Data coding, using a Fortran Coding Form, was done by batch. Transfer of coding information to SPSSx commenced March 27, 1993 and was completed April 3, 1993. Data collection terminated at noon, March 30, 1993.

### Measures

The research can be characterized as a descriptive, cross-sectional sample survey of 100 randomly selected employees of George Pearson Centre.

An attitudinal self-administered mail questionnaire was chosen for its inherent strengths, particularly feasibility, in asking uniform questions of a relatively large number of individuals. This method was chosen also for its ability to counteract two issues: explicit researcher bias and the sensitive nature of the subject-area because of fear of change.

### Limitations

The study has recognized limitations, namely the ability to elicit contextual data about process.

The research design precludes the generalization of data to populations other than the sample population. The design and poor response rate preclude inferences about causal relationships.

### Variables

Variables were intended to measure perceived participation and degree of agreement with strategic goals and acceptance of the strategic plan itself; to describe demographics and to explore staff-perceived issues potentially affecting implementation of

strategic goals. Variables were identified through formal and informal discussions with stakeholders, by observing the work-setting informally for several months, by examining strategic planning documents and organizational policies and by reviewing the literature.

Variables explored four loosely-organized categories: demographics, content, process and organizational climate.

Demographic variables included respondents' age, educational level, length of employment at George Pearson Centre and first language. Additionally, subjects' role within the organization, non-professional direct caregiver, professional direct caregiver, administrative/support staff or management/supervisory role, is delineated.

Content variables were concerned primarily with staff attitudes about the content of the strategic plan itself. Using a five-point Likert scale, the questionnaire explored respondents' level of agreement with each of the five strategic goal statements. The research attempted to identify the goal statement which staff felt would be the easiest to achieve and most difficult to achieve.

In an effort to explore the overall feeling at George Pearson Centre respondents were asked to proffer a third-party assessment of the degree of staff's endorsement of the strategic plan. Respondents were asked, "In your opinion, how well is the strategic plan accepted by staff at George Pearson Centre?" A five-point Likert scale was utilized for responses which ranged from "1 - completely accepted" to "5 - completely rejected."

In an attempt to ascertain staff perception of the impact of the strategic plan, the questionnaire asked, firstly, "Will the strategic plan affect employees at George Pearson Centre?" Those who answered affirmative were then asked through an open question to indicate "What effect will it (the strategic plan) have?"

Also relating to content, subjects were asked to comment on their perceived level of understanding of the strategic plan. The questionnaire used a five-point Likert scale, responses ranging from "1 - very good understanding" to "5 - very poor understanding."

Process variables pertained to the strategic planning process and staff's involvement in and attitude about it. Research endeavoured to ascertain the staff's first awareness of the Society's (intention to undergo) strategic planning. Subjects were asked, "When did you first hear about B.C. Rehab's Strategic Plan?" Four choices were offered: "when B.C. Rehab first decided to do a strategic plan; when the strategic plan was being developed; after the strategic plan was set; I had not heard of it before today."

A number of variables attempted to determine staff's participation in the planning process. Firstly, subjects were questioned about their opportunity to participate. They were asked, "Did you have the opportunity to express your opinions about the strategic plan?" Those who answered "no" were then asked if they would have liked the opportunity while those who answered "yes" were asked to discuss when the opportunity presented itself and if they took it. Also, respondents were asked how they gave their

opinions. Possible answers included "discussions with my manager or supervisor, in meeting(s) called by management to discuss the plan, as part of a strategic planning working group or committee, in writing as part of a report or brief." Additionally, respondents were invited to list other opportunities.

Respondents who indicated that they had participated in the planning, were asked how they felt about the experience. Two questions were asked, "How comfortable did you feel about giving your opinion?" and "How seriously would you say your opinions were taken?" A five-point Likert scale was utilized to measure responses to both questions.

Two open-ended questions were posed in order to elicit subjects' ideas about the reasons the strategic plan might not be accepted by staff and barriers which must be overcome before the plan's implementation will be successful. The former question was asked of those subjects who indicated that staff mostly or completely reject the plan--"If you feel the plan is not accepted, why not?" The latter question was worded: "In your opinion, are there concerns which must be addressed by administration before the strategic plan can get started?"

As previously described, Aiken & Hage's Scales of Personal Participation in Decision Making and Hierarchy of Authority were included to acquire information concerning organizational climate.

### Reliability of the Measure

Since the instrument is not a standardized measure, reliability is of concern. An internal consistency reliability check was included in the measure. Two items were repeated. One item related to staff acceptance of the strategic plan (#11 & #25) and one related to staff's first awareness of the organization's strategic plan (#5 & #17).

The two repeated variables for acceptance, when cross-tabulated, revealed a perfect correlation. The variables for first awareness also revealed a strong positive correlation,  $p < .001$ .

### Validity of the Measure

The measure appeared to have face validity as judged by the researcher and two individuals, each of whom has a Master of Social Work degree.

The Aiken and Hage scales of Personal Participation in Decision Making and Hierarchy of Authority were included in the questionnaire and administered, with permission (see Appendix C), concurrently. Inclusion of The Aiken and Hage Scale of Personal Participation in Decision Making provided comparative data on which to determine the concurrent validity of the researcher-constructed measure of participation. Miller (1991) supports this scale as having validity in measuring participation in organizational decision-making (see page 412 for detailed description.) It should

be noted, however, that documentation on this scale does not provide reliability information.

When cross-tabulated, the variable indicating opportunity for participation and the variables comprising the Aiken & Hage's Personal Participation in Decision Making demonstrated a strong, positive correlation (Pearson's  $r$ ,  $p < .05$ ).

### Threats to Validity

Coinciding approximately with this project were two events which the researcher identifies as possibly threatening the internal validity of this research. The first is the coincidental job action against B.C. Rehab by the employees of the George Pearson Centre. Two factors are notable:

- (1) the employees' perception of management's adversarial approach during the strike-- the perceived reluctance of management to "sit down at the table" with the striking employees
- (2) when the job action ended, the issues were not resolved. Employees returned to work but a mediator was scheduled to review the issues and make non-binding recommendations by April 5, 1993. During data collection period, employees were aware that further job action by staff was a possibility.

A second threat to internal validity was identified, namely the Provincial government's announcement to close Shaughnessy Hospital. The announcement, made in early February, 1993, sparked

controversy throughout the health care system. Employees of other health care institutions articulated fears around the possibility of losing their jobs as a result of similar government initiatives. Additionally, they expressed concerns about their being "bumped" by displaced Shaughnessy workers. There is a sense that health care jobs will become more scarce and that workers will not risk leaving their positions for fear of not finding alternative jobs.

Potentially, the political climate (micro and macro) may have caused subjects to respond less favourably to B.C. Rehab's strategic goals, many of which can be identified with (and indeed have been advertised by B.C. Rehab as) aligning with the Province's "closer to home" health policy.

### Data Coding

The values of each variable were assigned numeric codes and recorded into a code book. As questionnaires were returned, responses were assigned appropriate numerical codes and were recorded on a Fortran Coding Sheet. Quantitative data was then entered into the SPSSx program for analysis.

The qualitative data generated by the questionnaire's open questions were categorized by the researcher into mutually exclusive categories. Each category was assigned a numeric code and responses were coded accordingly for quantification.

### Analysis Plan

Each response to the open-ended questions was read, recorded on a file card and categorized according to theme. All responses were placed in one category, and only one category. The creating of categories was guided primarily by theory; the number of categories needed to include all responses determined the number of categories which were created. (Hessler, 1992) Quotes by category were transcribed into a personal computer for inclusion in the analysis of results or conclusions.

The low return (n=47) resulted in small cell sizes, particularly for variables which were part of a decision tree format. To maintain statistical significance, several coding categories were necessarily collapsed.

As mentioned previously, two organizational variables, participation in decision-making and hierarchy of authority, were examined using Aiken and Hage scales of Personal Participation in Decision Making and Hierarchy of Authority. These instruments were originally developed to reflect the properties of organizations. The author-recommended procedure for computing organizational scores is to weight each respondent's scores according his/her position in the hierarchical stratum. This method

attempts to represent organizational life more accurately by not giving disproportionate weight to those social positions that have little power and that are little involved in the achievement of organizational goals. (Aiken & Hage, 1967, p.918)

However, the authors suggest that an

alternative procedure for computing organizational means is to weight all respondents equally. These two procedures yield strikingly similar results for the variable reported in this paper. (Aiken & Hage, 1967, p.918)

Given this information and for the sake of simplicity, an unweighted mean score was calculated for each of these two organizational variables.

### Tests of Significance

Pearson's Correlation (Pearson's  $r$ ) was selected to calculate statistical significance. Chi-square was deemed inappropriate because of the high frequency of expected cell sizes of less than five (Weinbach and Grinnell, 1991).

It is recognized that Pearson's  $r$  is most appropriately used with data emanating from interval or ratio level variables. A review of social work research literature reveals that in some instances the usual requirements for the use of statistical tests can be disregarded (Yegidis and Weinbach, 1991).

The data generated by this research was primarily rank-order data and strictly speaking does not meet the requirements of the Pearson's  $r$  test. However, consistent with common practice in social work research, the ordinal level data is treated as interval level.

## CHAPTER IV - RESULTS

Within this chapter the findings of the research project will be presented. A review of the research questions is followed by the findings.

### RESEARCH QUESTIONS

This research project addresses four questions:

What are George Pearson Centre staff attitudes to the content of the strategic plan?

What are George Pearson Centre staff perceptions of their participation in the development of the strategic plan?

What is the relationship between the staff's perception of its participation and its attitude toward the strategic plan?

What are staff-identified concerns regarding implementation?

### FINDINGS

Demographic data reveal that 68% of those surveyed were between 31-50 years of age. Seventy-five percent of non-professionals and 56% of professionals report falling within this age range. Twenty-eight percent of professionals as compared to 14% of non-professionals are between the ages of 51 and 60.

Sixty-one percent overall report having at least some college education. Eighty-three percent of the professional group and 31%

of the non-professional group report having university graduation.

Nearly one-half of all employees surveyed have been employed by the organization for five years or less. Over two-thirds of the professional group falls within this category as compared to 38% of the non-professional group. Also notable is the fact that one in five of the non-professional group report length of employment to be sixteen or more years. This compares to 6% reported by the professional group.

Thirty-eight percent of all surveyed staff indicated that English was their second language. In the non-professional group, over half reported English as a second language. This compares with 17% reported by the professional group.

For details of socio-demographic data, see Table 5 Socio-Demographic Information.

<b>Table 5</b>			
<b>SOCIO-DEMOGRAPHIC INFORMATION</b>			
	<b>ALL SURVEYED EMPLOYEES N=47</b>	<b>NON PROFESSIONAL N=29</b>	<b>PROFESSIONAL N=18</b>
	<b>Percent N= ( )</b>	<b>Percent*</b>	<b>Percent*</b>
<b>AGE</b>			
21-30	11 (5)	7	16
31-40	36 (17)	41	28
41-50	32 (15)	34	28
51-60	19 (9)	14	28
61-65	2 (1)	3	-
<b>EDUCATION</b>			
High School	28 (13)	41	6
Some College	10 (21)	28	11
University Grad	51 (24)	31	83
<b>LENGTH OF EMPLOYMENT</b>			
0 - 5 years	49 (23)	38	66
6-10 years	17 (8)	14	22
11-15 years	19 (9)	28	6
16+ years	15 (7)	21	6
<b>FIRST LANGUAGE</b>			
English	62 (29)	48	83
Other	38 (18)	52	17

\*Note: percentage figures are rounded.

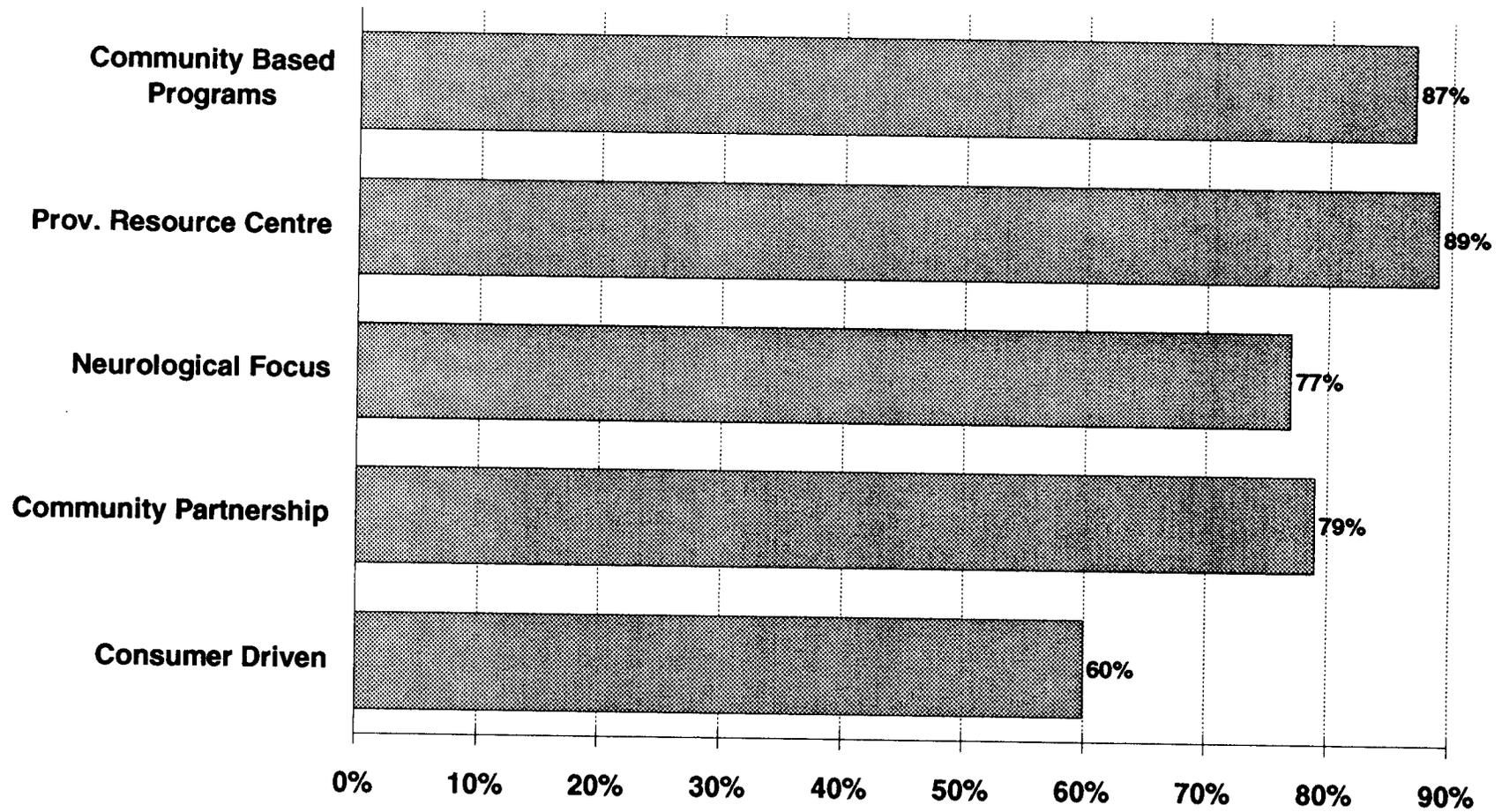
Agreement with the following five strategic goals was examined:

- Goal #1 B.C. Rehab will commit to a consumer-driven policy and practice framework in all aspects of our work.
- Goal #2 B.C. Rehab will pursue community partnership in planning, delivery, research and funding of rehabilitation services.
- Goal #3 B.C. Rehab will focus clinical activity on the rehabilitation of individuals with neurological disabilities.
- Goal #4 B.C. Rehab will become a provincial resource centre in rehabilitation education, research and technology.
- Goal #5 B.C. Rehab will become a resource centre for specialized community-based programs supporting people with disabilities.

Each of the five goals received high percentage agreement from respondents as a whole. The first goal (consumer-driven framework) generated the lowest level of overall agreement (60%). Nearly one-third of respondents indicated having "no opinion" about this goal. This goal also received the highest degree of disagreement.

Goal #4 (commitment to research and education) received highest agreement at 89% and the lowest rate of "no opinion." This was followed very closely by the fifth goal (B.C. Rehab as a community resource centre) which realized 87% agreement. Agreement levels for all goals are outlined in Figure 1 Percentage Agreement by Goal, page 86. Note that for the purposes of Figure 1, the values "strongly agree" and "agree" were collapsed.

**Figure 1 Percentage Agreement By Goal N = 47**



The breakdown for values comprising each of the five goal variables is detailed in Table 6 Percentage Results of Attitude Toward Strategic Goals.

Table 6 ATTITUDE TOWARD STRATEGIC GOALS N=47				
	Agree	No Opinion	Disagree	No Answer
	%	%	%	%
GOAL #1	60	32	6	2
GOAL #2	79	21	-	-
GOAL #3	77	19	4	-
GOAL #4	89	11	-	-
GOAL #5	87	13	-	-

Note: Percentage figures are rounded.

Comparison of each of the five goals by employment group revealed some interesting results. Level of agreement with each goal was consistently higher for the professional/management group, particularly for Goals 1, 2 & 3, as indicated in Table 7 Agreement of Strategic Goals by Group.

Note that for the purposes of this and other group comparisons, the four groups (Direct Care Professional,

Managerial/Supervisory, Direct Care Non-Professional and Administrative/Support) were collapsed into two employment groups, Professional and Non-Professional. The "Professional" group includes Direct Care Professional and Managerial/Supervisory staff. The "Non-Professional" employment group includes Direct Care Non-Professional and Administrative/Support staff. Small cell sizes, particularly for the original Managerial/Supervisory and Direct Care Professional categories, necessitated the collapsing of categories.

Table 7

## AGREEMENT WITH STRATEGIC GOALS BY GROUP

GOAL	GROUP			
	Non-Professional N=29		Professional N=18	
	Percent	n	Percent	n
Goal #1	41.4	12	88.9	16
Goal #2	69.0	20	94.4	17
Goal #3	65.5	19	94.4	17
Goal #4	86.2	25	94.4	17
Goal #5	82.7	24	94.4	17

Similarly, the non-professional group scored consistently higher in the "no opinion" categories. This is evidenced particularly in Goals 1, 2 & 3 as indicated in Table 8 Percentage of "No Opinion" Scores by Group. While Pearson's r revealed low statistical significance for Goal #4 and Goal #5, calculations reveal a statistical significance for Goal #1 #2, and #3 of  $p < .05$ .

Table 8 "NO OPINION" SCORES BY GROUP					
	GROUP				
	Non-Professional N=29			Professional N=18	
	Percent*	n	Percent*	n	
GOAL #1	48	14	6	1	
GOAL #2	31	9	6	1	
GOAL #3	28	8	6	1	
GOAL #4	14	4	6	1	
GOAL #5	17	5	6	1	

\*Note: Percentage figures are rounded.

Sixty-eight per cent of the staff surveyed felt that the strategic plan will affect staff. One quarter felt the plan would

have no effect; 3 respondents gave no answer. Those replying in the affirmative were asked to specify the plan's effect on staff. Five of the 32 possible respondents did not answer. The remaining 27 produced a total of thirty-nine responses.

Two issues--job security and the need for staff to change roles, behaviours &/or attitudes--comprised over 80% of the responses and were equally cited (41% each). Typical of responses concerning job security:

Some employees may end up being let go.

The skills of staff here have to be changed through new staff being hired and/or some education to others.

restructuring and possible personal and professional losses or gains.

...some jobs eliminated, others created.

uncertainty of their present positions--job securities.

Incumbent changes in attitude, roles and behaviours are depicted in the following text:

Staff will require a change in attitude to parallel changing focus.

...less institutionalized attitudes and job performance.

It requires that employees shift attitudes significantly.

Attitudes will have to change and some changes in how we carry out our jobs.

Employees will need to adopt a 'doing with' stance instead of a 'doing to' attitude.

When asked to disclose their concerns about the strategic plan, 23% of respondents did not answer. More than two-thirds

(68%) indicated they had concerns while 8.5% indicated no concerns. Of those who had concerns, three were not specific. The remaining respondents (n=29) generated 37 responses. Issues regarding communication of information comprised a majority (46%) of the expressed concerns as depicted in the following excerpts:

Education to staff re strategic plan, how it affects them and how to deal with this change.

the idea of consumer-driven must be defined.

more information in plain language about the long term effect on staff and the future of residents, job security issues.

Seven responses identified organizational issues as concerns to be addressed:

There are managers...who do not fully buy the plan themselves and undermine the work.

Supervisors need to relax complete control and encourage staff to actively participate in decision-making.

Yes, better staff/management relationships.

Five responses related to client issues; five responses to issues around job security and three were classified as "other."

The first variable to address the question of process asked respondents to indicate when they first became aware of the strategic plan. Overall, one out of five staff indicated no awareness of the plan before receiving the research questionnaire. An additional one out of five indicated awareness only after the plan was set. One-third indicated their first awareness occurred when the plan was being developed and 23% stated their first awareness when the organization first decided to undertake

strategic planning.

When considered by employment group, results demonstrate earlier awareness by the professional group. Well over 2/3 of the Professional Group indicated awareness of the plan before or during its development while, in the same period, only 45% of the Non-Professional group were aware. Also notable is the extent to which the non-professional group indicated its lack of awareness of the plan at the time of the research, relative to the Professional Group. Pearson's  $r$  reveals  $p. < .05$ . These results are summarized in Table 9 First Awareness of Strategic Plan by Employment Group.

<b>Table 9</b>				
<b>FIRST AWARENESS OF STRATEGIC PLAN BY EMPLOYMENT GROUP</b>				
<b>FIRST AWARENESS</b>	<b>GROUP</b>			
	<b>Non-Professional N=29</b>		<b>Professional N=18</b>	
	<b>Percent*</b>	<b>N</b>	<b>Percent*</b>	<b>N</b>
<b>When B.C. Rehab First Decided</b>	17	5	33	6
<b>During Development of the Plan</b>	28	8	39	7
<b>After the Plan Was Set</b>	17	5	22	4
<b>No Previous Awareness of the Plan</b>	31	9	6	1
<b>No Answer</b>	7	2	-	-

Note: Percentage figures are rounded.

When asked if they had been afforded the opportunity to participate in the strategic plan, 60% answered negative. Just

over one-third of staff surveyed indicated they had an opportunity to participate. Delineation of this variable by group, revealed a difference between the rate of opportunity of those in the professional/management group to provide input to the strategic planning process as compared to the group with the non-professional designation,  $p < .01$ . Table 10 Opportunity for Input provides details.

Table 10						
OPPORTUNITY FOR INPUT						
OPPORTUNITY	All Staff N=47		Non-Professionals N=29		Professionals N=18	
	Percent*	N	Percent*	N	Percent*	N
Yes	34	16	14	4	67	12
No	60	28	79	23	28	5
No Answer	6	3	7	2	5	1

Note: Percentage figures are rounded.

Of those who indicated no opportunity to participate, over two-thirds indicated that they would have liked the opportunity. Twenty-nine per cent indicated they did not want the opportunity. One respondent did not answer.

Respondents who indicated that they did have the opportunity

to give their opinions were asked if they took advantage of that opportunity. A full 94% stated that they took the opportunity. Participation rates are detailed in Table 11 Participation in the Strategic Plan.

<b>Table 11 PARTICIPATION IN THE STRATEGIC PLAN</b>						
<b>PARTICIPATION</b>	<b>All Staff N=47</b>		<b>Non-Professionals N=29</b>		<b>Professionals N=18</b>	
	<b>Percent</b>	<b>N</b>	<b>Percent</b>	<b>N</b>	<b>Percent</b>	<b>N</b>
<b>YES</b>	34	16	14	4	67	12
<b>NO</b>	66	31	86	25	33	6

Note: Percentage Figures are Rounded.

Of the sixteen respondents who participated in the planning, over two-thirds (69%) stated that the opportunity came when the plan was in the developmental stages. Two respondents (12.5%) indicated that the opportunity was presented after the strategic plan had been approved. The remaining 19% were unsure or did not answer.

Seventy-five per cent of those who participated in the planning process indicated that they were comfortable doing so; three respondents indicated they were uncomfortable; one respondent did not answer.

Of those who participated, 62% felt their opinions were taken seriously while most of those remaining reported they were "unsure." One did not answer.

Over one-third of all staff surveyed indicated their understanding of the strategic plan to be good. Thirty-two percent felt they had some understanding.

Delineation by employment group reveals a relatively more impoverished understanding by those designated non-professional. Pearson's  $r$  reveals  $p < .01$ . Comparative results are detailed in Table 12 Understanding of the Strategic Plan.

Table 12 UNDERSTANDING OF THE STRATEGIC PLAN						
UNDERSTANDING	ALL STAFF N=47		NON-PROFESSIONALS N=29		PROFESSIONALS N=18	
	Percent	N	Percent	N	Percent	N
Good	36	17	17	5	67	12
Some	32	15	38	11	22	4
Poor	28	13	38	11	11	2
No Answer	4	2	7	2	-	-

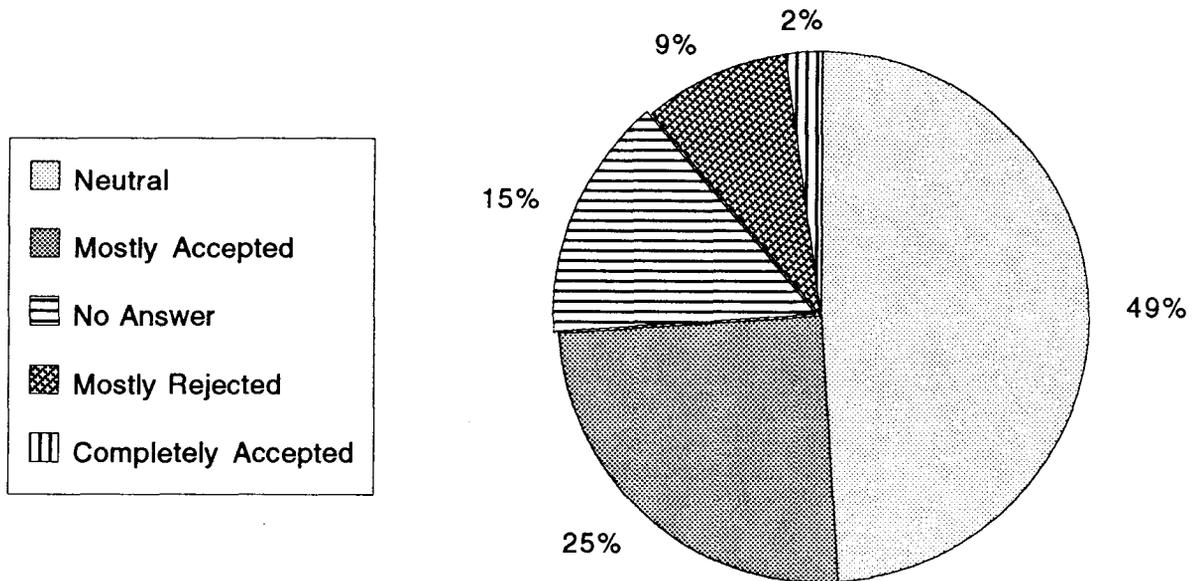
Note: Percentage Figures are Rounded.

Respondents' perception of staff acceptance of the strategic plan (N=47), revealed that nearly one-half felt staff were neutral about the plan, one-quarter felt staff mostly accepted the plan.

One out of eleven staff members felt the plan was rejected by staff.

Because the question which generated this data asked for a third-party assessment, the results cannot stand on their own. The question was originally set, not for the purpose of acquiring "hard" data as to attitude but to get a sense of the ambiance or prevalent mood. The results generated by this question are capsulized in Figure 2 Degree of Perceived Staff Acceptance of the Strategic Plan, page 98.

Figure 2 Perceived Staff Acceptance of Strategic Plan N = 47



When delineated by employment group, results showed the professional group's perception of acceptance within the organization is higher than that of the non-professional group. Table 13 Perceived Staff Attitude to the Plan by Employment Group provides a summary of results from this bivariate analysis. Pearson's r test revealed no statistical significance ( $p=.63$ ). Results are included because of their assumed clinical significance.

There is some suggestion in the literature that ambivalence or apathy are passive forms of resistance and function contrary to enrolment and commitment to planned change (Senge, 1991). If categories were collapsed to reflect this perspective, results indicate that more than 62% of non-professionals assess staff's attitude as that of non-acceptance. Using these parameters, a full one-half of the professional staff would assess the overall attitude as that of non-acceptance.

Table 13

**PERCEIVED STAFF ATTITUDE TO STRATEGIC PLAN  
BY EMPLOYMENT GROUP**

PERCEIVED ATTITUDE	NON-PROFESSIONAL N=29		PROFESSIONAL N=18	
	Percent	N	Percent	N
Accepted	24	7	39	7
Neutral	55	16	39	7
Rejected	7	2	11	2
No Answer	14	4	11	2

Note: Percentage Figures are Rounded.

Mean scores were calculated for the two organizational variables, participation in decision-making and hierarchy of authority, as generated from Aiken and Hage scales of Personal Participation in Decision Making and Hierarchy of Authority.

Overall mean score for participation in decision making was 4.27 (a score of 5 denoting no participation, a score of 1 denoting full participation).

Overall mean score for hierarchy of authority was 2.64, (a score of 1 denoting high deference to hierarchical authority, a score of 5 denoting low deference to hierarchical authority.)

CHAPTER V - DISCUSSION

There were several goals in conducting this case study. The first was to ascertain George Pearson Centre employees' attitudes toward and concerns about B.C. Rehab's strategic plan. The second was to determine the process by which B.C. Rehab developed the strategic plan and, in conjunction, determine employees' perception of their involvement in this process. Finally, the study attempted to identify the influences which may have affected the organization's choices around processes of strategic change.

The information for this case study was derived by three methods. Firstly, prior to the commencement of formal research, the author had knowledge of some policies and procedures of George Pearson Centre. Additionally, she observed and participated in discussion with employees and planners about the strategic plan. Secondly, information about B.C. Rehab's strategic planning experience was obtained through examination of B.C. Rehab documents, the results of which are contained in the introductory chapter. Academic and professional literature was reviewed. These results comprise the second chapter entitled Literature Review. Finally, a questionnaire was distributed to a sample of 100 randomly selected employees of George Pearson Centre to elicit information on three issues. Firstly, it examined employees' attitudes toward and concerns about the strategic plan. Secondly, it explored employees' perceived participation in the planning. Thirdly it attempted to determine what, if any, relationship

existed between employees' participation and their attitude toward the strategic plan. The methodology for this research project is contained in the third chapter and the findings are outlined in the fourth, Results, chapter.

This chapter is an integration of the previous chapters. Its purpose is to pull the findings together, to identify emerging themes and to provide some interpretation of them.

While George Pearson Centre has evolved over the years in response to changing environmental conditions, none of the changes it previously experienced were as comprehensive as those suggested in the current strategic plan. Previous changes were incremental in nature, adjustments to the existing service delivery system. As chronicled by the B.C. Rehabilitation Society (1992d), they were unplanned responses to changing conditions. A prime example is Pearson's response to the 1954 "outbreak of polio. . . which produced hundreds of new patients in the province" (p.6). By responding to the polio epidemic, the institution changed its focus to non-ambulatory patients; emanating from this an expertise in respirator-dependent care developed. This, in turn, "meant that non-polio patients with breathing problems also became residents" (B.C. Rehabilitation Society, 1992d, p.9). While these developments had a significant impact on the organization and the community, they were not planned. Nor were they radical. Pearson Hospital remained a hospital in both infrastructure and orientation.

The current change effort, by comparison, is an "intentional process, a conscious and deliberate intervention to change a specific situation" (Kettner et al., 1985, p.7). The planned changes are radical, challenging the philosophical underpinnings of the organization's service delivery system. The organization's decision, for example, to "commit to a consumer-driven policy and practice framework" (B.C. Rehabilitation Society, 1992b, p.4) is intended to make fundamental changes to the way services are delivered. It will, undoubtedly, have a dramatic impact on the issues of organizational control and accountability. This is also true of the other philosophical goal which proposes the organization's refocusing from a primary to tertiary care.

Some of the impetus for the organization's strategic change was brought to bear by consumer advocacy groups who lobbied for changes in the delivery of services to people with disabilities. Single-interest groups, comprised primarily of people with disabilities, have advocated for the right of disabled people to direct their own care and their own lives. They have demanded that they, the consumers, be the locus of control and that service providers be accountable to them (Sutherland, 1981).

It could be suggested from this that some of B.C. Rehab's proposed changes are in response to a social action approach, since many of the changes are essentially a "redistribution of power, resources and/or decision-making . . .(and involve) changing basic policies of formal organizations" (Rothman and Tropman, 1987, p.6)

However, B.C. Rehab's change effort was more than a single-

issue response. It was a comprehensive response to a complex set of conditions. Although some of the conditions antecedent to the strategic change effort were consistent with those described by Kettner et al--"the increasing focus on the needs of special populations, the decline in resources available for human services and increasing pressures for accountability" (p.3), there were others as well. They included B.C.'s changing demographics (Havens, 1981), the impact of technological advances on the demographics of the disabled population (National Council on Welfare, 1990) and the provincial government's movement towards decentralization (Seaton, 1991).

B.C. Rehab's experience is consistent with Turton's (1991) observation that the hierarchical level of decision-making covaries with the nature of the problems confronting the organization. In this case the antecedent conditions and the needed changes were sufficiently complex to demand the decision-making power of those occupying upper-level positions.

As evidenced by the high hierarchical position of the change agents and by the radical, comprehensive nature of the proposed changes, the George Pearson Centre experience is appropriately classified as "strategic." It falls within Tichy's (1983) definition of strategic change as "nonincremental...change which alters the overall orientation of the organization" (p.17)

The impact of B.C. Rehab's change effort is consistent with that traditionally expected of strategic change. It, more than other type of change, is reported to yield great uncertainty not

only for the organization as a whole but also for its stakeholders, notably its staff (Turton, 1991). Adding to the uncertainty is the timescale. B.C. Rehab's change effort has continued, formally and informally, over the period of a decade and is scheduled to continue formally, until at least 1997. Turton's observation that, "the longer the timescale, the greater the complexity and the likely degree of uncertainty... experienced" (p.198) appears to hold true at George Pearson Centre with the confirmed presence of uncertainty and concern among staff.

While some degree of uncertainty may "go with the territory," results suggest that the system of strategy development and its approach to communication contributed to employees' apprehension. Pearson Centre employees perceived communications originating from change agents as sporadic and "one way," that is top-down, with little provision for a two-way flow. Alpaender and Gutmann (1974) suggest that uncertainty, fear of the unknown, is a leading cause of employee resistance. They maintain, however, that it can be reduced by simply providing employees with appropriate information.

B.C. Rehab followed a corporate planning framework (Schaffer, 1967). The process commenced with research of the issues, followed by an external environmental analysis and assessment of the organization's internal strengths and needs. On the basis of the research results, the mission statement was revised. Upon its reformulation, Schaffer's second stage, strategic planning followed--commencing in May, 1991--with the formation of a Strategic Planning Department. Although not so-delineated by the

organization, the latter months of the planning process constituted Schaffer's last stage, the beginning of operational planning. At this time, typical of processes adhering to strategic planning models (Chakravarthy and Lorange, 1991), the organization involved those occupying lower-level management and supervisory positions. This would account for why 29% of the organization's most powerful group, its professional/management sector (Mintzberg, 1978) stated that they had not heard of the plan until after it was set.

Documents state that strategic planning was completed in June, 1992, and the first year of the implementation process began. It should be noted that even at the end of Year I of implementation, operational planning continued, involving middle and lower management and the co-ordinator of the former strategic planning department. This, too, is somewhat typical of the planning perspective in strategy formation which sees responsibility for the overall process as belonging, in principle, to the Chief Executive Officer (C.E.O.) with responsibility for the plan's execution resting, in practice, with staff planners (Mintzberg, 1990). This is also indicative of the organization's commitment to a social planning approach where

rational, deliberately planned, and controlled change has a central place. . . . community participation may vary from much to a little depending on how the problem presents itself and what organizational variables are present. The approach presupposes that change in a complex . . . environment requires expert planners who, through the exercise of technical abilities, including the ability to manipulate large bureaucratic organizations can skillfully guide complex change processes. (Rothman and Tropman, 1978, p.6)

The issue of employees' participation in the planning process and the nature of communication with employees were pre-determined by the organization's decision to use a planning approach and specifically a strategic planning approach to formulate its strategy. Strategic planning, by definition, precludes broad-based participation and is "conducted at the top of the organization and at the top of the organization's major divisions or product groups" (Anthony, 1985, p.4). To a large extent, B.C. Rehab held to these principles. Particularly in the stages prior to operational planning (Schaffer, 1967), strategy development was the purview of the organization's upper-echelon. Documentary evidence states, however, that even during operational planning, employee participation was restricted to those occupying lower-level management and professional positions within the organization (B.C. Rehab, 1992c, p.3).

The decision to commit to a strategic planning model mirrored the organization's roots in traditional structure, its strong commitment to a medical model of practice and its orientation as a professional bureaucracy. These organizational structures have had considerable influence in determining who would participate in the change effort.

As B.C. Rehab embarked upon strategic planning, its decision-making processes appear to have been highly centralized in the upper levels of the organization's hierarchy. To a large extent, employees' responses to the research confirm this. In addition to their perception of the organization as highly centralized, they

perceive the organization as adhering rigidly to hierarchical authority. There appears to be consistency between employees' attitudes about hierarchy and decision-making and the organization's structure as illustrated in the George Pearson Centre Organizational Chart (Appendix A). The organizational chart reveals a departmentalized organization, supporting a large-scale middle management hierarchy. In many respects, the organization falls into the category of what Mintzberg (1983) refers to as a "machine bureaucracy." The rigid structures of such organizations, according to this author, beget "alienated employees, an obsession with control and an inability to adapt" (Mintzberg, 1983, p.12).

George Pearson Centre, from its beginnings as a hospital, adheres to a medical model of service. This model predicates the power and authority of medical professionals on the presumption of the discipline's superior ability to address issues (Kari & Michels, 1991). To a large extent, George Pearson Centre's service is dependent on the expertise of medical professionals. This reliance is demonstrated and supported in the organization's structure which, as illustrated in the organizational chart (Appendix A), is highly departmentalized along a functional model--largely according to professional discipline.

George Pearson Centre confers much influence and power on its professionals although this group is a numeric minority, constituting only 30% of the employee population. Although structurally, George Pearson Centre displays many characteristics of a "machine bureaucracy," it also has many of the attributes of

a "professional bureaucracy." According to Mintzberg (1983) professional bureaucracies are highly decentralized and participative with respect to their professionals. They are, however, equally non-participative and centralized with respect to those in non-professional designations. Consistent with this, the majority of those participating in George Pearson Centre's decision-making processes originate primarily from within the ranks of professional or managerial designations. The professional group, relative to its size, was significantly over-represented while the non-professional group was likewise under-represented in the strategic planning effort.

B.C. Rehab documents outline the principles intended to guide the organization's planning:

. . . participation by staff at all levels and in all parts of the organization. . .

Planning. . . viewed as a developmental process that will equip staff both to maintain a strategic vision and to take on planning as an ongoing function of line management. . . .

Planning. . . centred in mutual respect, teamwork, and a drive for continuous improvement. (B.C. Rehabilitation Society, 1992c, p.6/7)

These principles depart from traditional strategic planning methodology, particularly with regard to staff participation. In many aspects, they are more closely aligned with the "learning school of thought" which suggests that "the complex and dynamic nature of the organization's environment precludes deliberate control" (Mintzberg, 1990, p. 155). This perspective asserts that

"deliberate control" in the planning process must be relaxed in favour of collective, stakeholder participation and

strategy making must. . .take the form of a process of learning over time, in which, at the limit, formulation and implementation become indistinguishable.

While the leader must learn too and sometimes (is) the sole learner, more commonly it is the collective system that learns;

. . .learning proceeds in emergent fashion through behavior that stimulates thinking retrospectively, so that sense is made of action. . . strategic initiatives are taken by whoever has the capacity to learn and the resources to support that capacity. (Mintzberg, 1990, p.155)

Despite B.C. Rehab's guiding principles and the leadership's desire to relax control and avoid "going 'from the top down'" (B.C. Rehabilitation Society, 1992c, p.6), results suggest that broad-based employee participation was not fully realized. The tenets of participation applied to the professional group but not to the non-professional. In many respects this incongruity between policy and practice is a benchmark issue. The factors which contribute to the resistance of this policy are also the same factors which will ultimately influence implementation of the strategic changes.

Several perspectives are appropriate when addressing the issue of resistance to such changes. In this case, the resistance appears to originate with those responsible for the policy's implementation, likely the organization's managers. The principles of employee participation are resisted because, despite their management roles, the incumbents do not share the leadership's vision (Senge, 1991) a result, in part of their lack of involvement

in its development. As a result, they feel no sense of "ownership" of the ideology (Whyte, 1991).

Mintzberg (1990) suggests that in certain environments, organizations

may be better off with a forceful leader who already has a strategic vision to save it (the organization) or at least can develop one quickly. Even when not in crisis, some organizations need strategic visions that are novel and tightly integrated. . . and these are more likely to come through a centralized entrepreneurial approach than one of decentralized learning. (Mintzberg, 1990, p.157)

This appears to be the case with B.C. Rehab. It appears that necessitated by the technological, social, political and economic conditions facing the organization, B.C. Rehab's "vision" has emanated from the leadership, without the concensus of lower-level bureaucrats. The team of top executives, led by the C.E.O., remains the architect of strategy. Even in Year I of implementation, the task at hand is to "selectively move people toward a broadly conceived organizational goal" (Quinn, 1980, p.32). This process is aptly described as "political implementation" (Mintzberg, 1990).

The Alpander and Gutmann (1974) thesis that resistance can be mitigated through the adequate provision of information is perhaps a simplistic approach in settings where change challenges the fundamentals of an organization. To address the issue of resistance, its existence must first be diagnosed. Managers and other employees although heavily invested in the status quo often do not wish to be perceived as non-compliant. Their dissonance often results in what Hardy (1992) refers to as "passive

resistance" characterized as: " 'Me fighting the plan? Why, I'm doing everything you told me to do, boss!'--and nothing more" (Hardy, 1992, p.72). The "nothing more" is the crux of passive resistance. The participatory processes advocated by the planning principles are cumbersome and time-consuming (Makridakis et al., 1982). To be successfully implemented, such principles must enjoy a high level of commitment from those charged with their implementation. Given the demands that participatory models place on scarce resources (staff time, managerial time, financial resources) relative to more centralized approaches, there is great potential for them to be undermined or dismissed, as untenable, by those not really in agreement.

Another possible explanation for the failure of the thrust towards participation may have been the threat it posed to the power of the organization's traditional decision-makers. This policy's poor implementation suggests that this issue engendered some dissension among managerial staff. In light of this, one cannot dismiss the possibility of the policy's having fallen victim to organizational politics or "activities to acquire, develop, and use power and other resources to obtain one's preferred outcomes in situations in which there is uncertainty of dissensus [sic] about choices" (Pfeffer, 1981a, p.7).

The organizational learning espoused by B.C. Rehab's statement of planning beliefs and values and by the learning perspective, generally, assumes that employees have skills in strategic thinking. The development of these skills requires a climate which

encourages individuals to think critically and retrospectively about the organization's previously-attempted behaviours and strategies (Mintzberg, 1990). Traditionally George Pearson Centre's organizational climate has not been conducive to the development of these skills, particularly in those employees designated as non-professional. It may, therefore, have been developmentally premature to expect the organization to welcome and successfully implement collective strategic thinking. Such "organizational revitalization through steady learning" (Mintzberg, 1990, p.153), is more appropriately a goal for B.C. Rehab's future than for the current strategic change effort.

Assumptions around the nature of organizational culture provide a useful perspective in addressing influences on George Pearson Centre's strategic change effort. The first assumption is that George Pearson Centre, like all organizations, has a dominant culture which has developed over time and is affected by and, in turn, affects the beliefs, attitudes and assumptions of its members (Scholz, 1986). The second assumption is that in fact, George Pearson Centre supports several, sometimes conflicting, sub-cultures (Pedersen and Sorensen, 1988). A comprehensive description of the Centre's culture(s) was outside the parameters of this study but the issue of culture is deserving of consideration. Examination of the organization's established policies and procedures in concert with simple observations of the physical and social environment hints at a culture which supports a paternalistic, control orientation and resists attempts to

deviate from the status quo.

Despite the fact that the organization is apparently refocussing its service delivery away from a medical or disease model, many of the artifacts of this orientation persist. Most noticeable is the sign in front of the building which refers to the facility as "George Pearson Hospital" [italics added] despite the fact that the name changed several years ago to "George Pearson Centre" [italics added].

A number of the facility's resident care policies and procedures reflect the medical model's protective attitude--its need to control and make decisions for residents. One artifact which reflects this aspect of culture is the strong presence of medical personnel in the ward teams and the time-honoured practice of professionals planning for residents, rather than planning in equal partnership with residents.

A cultural manifestation of the organization's strict sense of hierarchy and control is keenly depicted in informal social settings. For example during coffee or meal breaks, management figures remain cloistered at one designated table while other professional staff, support staff and nursing aides, each according to group, congregate separately. There is an unwritten rule or sense that one must not associate outside one's "class."

The organization's mission statement, reformulated and accepted by the Board of Directors in June, 1990, is still not in evidence in the Centre. However, until it was removed in March, 1993, to make way for renovations, a public notice board at George

Pearson Centre sported the previous mission statement.

In isolation, these may be perceived as insignificant. However these examples in concert with numerous others may be indicative of a dominant culture explicitly opposed to or passively resisting fundamental change. The climate or ambience with respect to the strategic plan appears to be one of ambivalence or resistance as reported by respondents in the survey. A quick look at the results reveals that only one in four respondents felt the plan was completely or mostly accepted. In addition to the 8% who felt the staff mostly rejected the plan, 40% felt the staff was neutral. There was no response by 15% of respondents. In total, a full 63% assessed the prevailing mood as either one of ambivalence or rejection or did not care to answer the question.

The strategic plan's content may, in many respects, be the embodiment of an emerging culture--a culture which takes its values and assumptions from the leadership's vision (Pfeffer, 1981). The value system of the emerging culture, however, appears to challenge many of the norms of the current dominant culture which, supported by a traditional organizational structure, seeks out a stable environment and actively resists change (Mintzberg, 1983; Pearson, 1990).

Research results reveal a reasonably high employee agreement with the content of four of the strategic goals. Receiving most agreement (89%) was the goal relating to B.C. Rehab as a provincial resource centre in rehabilitation education, research and technology. This goal has the least immediate impact on employees

and will likely generate the lowest operational effect (Judson, 1991) of any of the goals. That is, it is the least likely of all the goals to require substantial changes in behaviour, particularly of non-professional staff.

Following close behind is the goal which proposes that B.C. Rehab's focus shift from that of primary care to tertiary care, in support of a philosophy of decentralized service. Employees report high agreement with this goal, despite the fact that when implemented, this goal will have a significant operational effect. Documentary evidence states that changes in staff's work venues, duties, attitudes and behaviour will result (B.C. Rehab, 1992c).

The other philosophical goal, engenders significantly more controversy and received substantially less agreement (56%). The goal which commits B.C. Rehab to a consumer-driven framework, unlike the previously discussed goals, is inadequately explained. At the time of the research project, it had not yet been defined. The development of an operational definition has been identified as one of the priorities for the first year of the plan's implementation.

The degree of uncertainty surrounding this goal appears to separate it from the other four goals. In the absence of official information on its operationalization, many employees have formed their own, perhaps inaccurate, perceptions of this strategic thrust. In the minds of some, the implementation of a consumer-driven philosophy will require staff to undergo significant attitudinal and behavioural adjustments. Some believe that the

implementation of this goal will drastically alter power-relations between residents and staff; professional discretion being undermined by the consumer's wishes. Once again, the observations of Alpander and Gutmann (1974) that, "resistance to change stems largely from fear of the unknown. . ." (p.723), appear to hold true as employees appear to react to the uncertainty and lack of information about the first goal.

From an implementation standpoint, employees' low rate of agreement with this goal should be of concern. A full forty percent of respondents either disagreed with, gave no answer to or had no opinion about this goal. These results indicate that a large sector of staff that feels little or no commitment to a goal which is expected to underpin the organization's service delivery system. Translated into practice, the lack of commitment by two out of five employees may seriously affect the implementation of this goal and ultimately, the plan.

If one assumes that the non-professional group has a large role to play in accomplishing a consumer-driven framework, implementation concerns are further underscored. Substantially less than half (41%) of the non-professional group reported agreement with the "consumer-driven" goal.

Without adequate information on which to base their decisions and in the face of great speculation, it may be that employees' resistance to the consumer-driven goal is well-founded or at least rationally defensible. Particularly for those individuals who view it as a threat to established power relations or as contravening

traditional norms or ways of doing things, resistance is understandable (Judson, 1991; Senge, 1991).

Without their achieving an understanding of this goal, the best that can be expected from employees is their grudging compliance--they do what is expected of them although they do not see the benefits of the vision (Senge, 1991). The research was not intended to identify employees' behaviours, to identify their place along Senge's (1991) continuum of commitment to malicious disobedience and apathy. However, the research did identify a pervasive sense of employee ambivalence toward the strategic plan. How this ambivalence will translate behaviourally, is open to speculation. Certainly, it appears unlikely that those who feel ambivalent toward the goals are committed or even enrolled in the organization's vision.

While single variables cannot stand on their own to define associations, they can, in concert, present a picture. The results of this research reveal a particular pattern. Essentially, the largest group of employees appears to have been systematically excluded from participating in the strategic planning process. This, despite the fact that a major proportion of them indicated that, given the chance, they would have liked to participate. This same group indicated (relative to the professional group) a poor understanding of the plan and a lower rate of agreement with the goals.

In contrast, a larger percentage of the professional group was given the opportunity to participate and subsequently did

participate. Overall, they assessed themselves as having a better understanding of the plan and indicated relatively higher agreement with the goals.

This study cannot, nor was it ever intended to, infer causality. Certainly a review of the literature reveals numerous potential influences on employee participation and on employee attitude. To predict that employees' participation in the B.C. Rehab's strategic planning process would beget agreement with the plan would not only be a methodological error but would be a grave oversimplification of what turns out to be a very complex issue. It can be concluded that organizational culture, politics and structure appear to influence employee participation and employee attitude. It seems apparent also, that employees' participation in the process, their understanding of the plan and their agreement with the organizational goals are positively associated.

## **IN CONCLUSION**

While others are evident, one theme in particular emerges from this examination: that the organization's structure, its culture and its micro-political interests are interdependent and influence, either implicitly or explicitly, all organizational processes, including strategy development and implementation. These factors exert great influence on the opportunities presented employees and the degree to which employees participate in organizational decision-making.

The employee group which traditionally held positions of power at the Centre were those who were invited and ultimately took the opportunity to participate in the strategic planning process. On the whole they demonstrated more agreement with the organization's goals and objectives. Those who were not invited, and therefore did not participate, were those traditionally excluded from decision-making--namely those occupying non-professional positions. This group demonstrated lower agreement and higher ambivalence, overall. The proposed philosophical changes to a consumer-driven framework generated the most disagreement from staff although this goal will not necessarily have the most immediate nor the greatest operational effect on staff. The uncertainty surrounding this goal sets it apart from the others and may be a factor in employees' attitude toward it.

Although not unexpected, the uncertainties surrounding the strategic change, appeared to motivate many of the concerns. As implementation proceeds, employees are asking to be kept informed. They are asking for a better understanding--to be kept abreast, for more, current information from planners and upper-level management. They are asking, too, for the opportunity for two-way communication, for input into the process.

### RECOMMENDATIONS FOR FURTHER STUDY

From this study, there is reasonable evidence to support an association between the staff's participation in the planning and acceptance of the strategic plan. However, the research design did not produce data that were generalizable.

There are many questions emanating from the data which should be explored from a contextual perspective. Such exploration could be accomplished through a face-to-face interview or focus group format. These methods could more fully explore employees' feelings about the strategic change experience and elicit rich contextual data to help make sense of employees' reactions to the strategic change effort.

An inquiry should be made into the existence, causes and effects of staff's ambivalence toward the strategic plan. Although not stated unequivocally, much of the literature implies that ambivalence translates into a lack of commitment. If this is indeed, so, addressing this issue would be vital to implementation of any strategic plan.

Although some of this study's results indicated that culture may be a significant consideration, it was outside this study's mandate to examine the organizational culture at George Pearson Centre. The literature suggests that organizational culture is one of the most important factors influencing strategic change efforts. An ethnographical study would be useful in describing the various levels of George Pearson Centre's culture and determining how it

ultimately affects and is affected by organizational change efforts.

Another aspect worthy of research attention is the prevalence and role of organizational politics at George Pearson Centre. Although unsubstantiated, there were a number of responses which indicated that internal power struggles and self-interest were not only evident but had a negative impact on the change effort.

The case study of strategic change at George Pearson Centre raises a number of research questions:

To what extent are employees ambivalent about the strategic change efforts?

What factors contribute to employee ambivalence?

What impact does ambivalence have on implementation of the strategic plan?

What are the beliefs, values, assumptions and artifacts of the culture(s) at George Pearson Centre?

What is the impact of the Centre's organizational culture(s) on its organizational change effort?

If George Pearson Centre has several cultures, how do they interact with each other?

To what extent is organizational politics in existence at George Pearson Centre?

What, if any, role do organizational politics and self-interest have in George Pearson Centre's organizational change efforts?

EPILOGUE

B.C. Rehab's decision to commit itself to strategic change was not only an act of wisdom and vision but was one of courage, as well. In light of the current socio-economic and political climate with its incumbent pronouncements of restraint, accountability and decentralization, the decision to undertake strategic change was, essentially, the organization's bid to survive.

The proposed strategic changes are consistent with B.C. Rehab's articulated belief that British Columbians with disabilities can be better served than they are currently. Guided by the five strategic goals, the strategic plan has become the vehicle through which the organization will adjust its service delivery system to meet the changing needs of its constituents.

By challenging the status quo, by opening to scrutiny every aspect of its philosophy, policies, structures and service delivery system, the organization and its players took considerable risk. The uncertainty engendered by the resulting plan demands and will continue to demand paralleled commitment from those who will ultimately implement it--community, service-provider and consumer alike.

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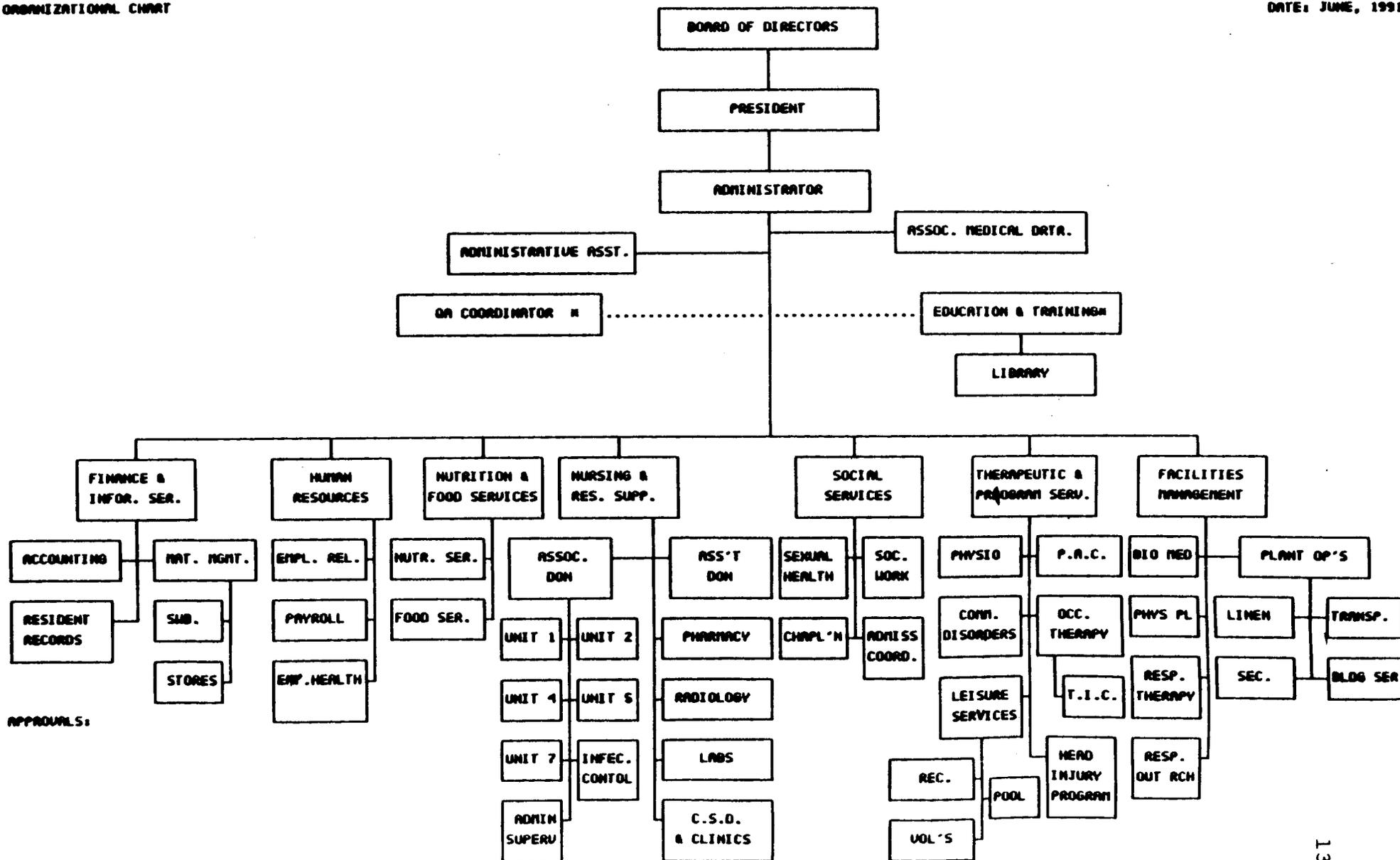
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APPENDIX A  
George Pearson Centre  
Organizational Chart



APPROVALS:

APPENDIX B  
Questionnaire

Strategic Planning Content and Process:  
Exploration of George Pearson Centre Employees'  
Attitudes and Implementation Concerns

QUESTIONNAIRE

Thank you for agreeing to participate. Your help is appreciated. Please be assured that all information will be kept in strict confidence. Names of those participating in this project will not be discussed with anyone.

Instructions: Read each question and **CIRCLE** the answer which best describes you

Let's begin with a little bit about yourself. **CIRCLE** the best answer.

1. What is your age?
  - a. 20 years or under
  - b. 21 - 30 years
  - c. 31 - 40 years
  - d. 41 - 50 years
  - e. 51 - 60 years
  - f. 61 - 65 years
  
2. What is your highest level of education?
  - a. Less than Grade 8
  - b. Some High School
  - c. High School Graduate
  - d. Some College/University
  - e. College/University Graduate
  
3. How long have you worked at George Pearson Centre?
  - a. under one year
  - b. 1 - 5 years
  - c. 6 - 10 years
  - d. 11 - 15 years
  - e. 16+ years
  
4. Is English your first language?
  - a. Yes
  - b. No

B.C. Rehab has developed a new strategic plan which will set the direction for George Pearson Centre for the next five years.

5. When did you first hear about the strategic plan?
  - a. when B.C. Rehab first decided to do a strategic plan
  - b. when the strategic plan was being developed
  - c. after the strategic plan was set
  - d. I had not heard of it before today

The strategic plan has five goal statements. CIRCLE the answer that best describes your feelings.

6. Goal statement #1:

"B.C. Rehab will commit to a consumer-driven policy and practice framework in all aspects of our work"

- a. strongly agree with this goal
- b. agree with this goal
- c. no opinion
- d. disagree with this goal
- e. strongly disagree with this goal

7. Goal statement #2:

"B.C. Rehab will pursue community partnership in the planning, delivery, research and funding of rehabilitation services."

- a. strongly agree with this goal
- b. agree with this goal
- c. no opinion
- d. disagree with this goal
- e. strongly disagree with this goal

8. Goal statement #3

"B.C. Rehab will focus clinical activity on the rehabilitation of individuals with neurological disabilities."

- a. strongly agree with this goal
- b. agree with this goal
- c. no opinion
- d. disagree with this goal
- e. strongly disagree with this goal

9. Goal statement #4:

"B.C. Rehab will become a provincial resource centre in rehabilitation education, research and technology."

- a. strongly agree with this goal
- b. agree with this goal
- c. no opinion
- d. disagree with this goal
- e. strongly disagree with this goal

10. Goal statement #5:

"B.C. Rehab will become a resource centre for specialized community-based programs supporting people with disabilities."

- a. strongly agree with this goal
- b. agree with this goal
- c. no opinion
- d. disagree with this goal
- e. strongly disagree with this goal

11. In your opinion, how well is the strategic plan accepted by staff at George Pearson Centre?
- Completely Accepted
  - Mostly Accepted
  - Neutral
  - Mostly Rejected
  - Completely Rejected
12. In your opinion, which of the five strategic goals will be the easiest to achieve?
- Goal #1
  - Goal #2
  - Goal #3
  - Goal #4
  - Goal #5
13. In your opinion, which of the five strategic goals will be the most difficult to achieve?
- Goal #1
  - Goal #2
  - Goal #3
  - Goal #4
  - Goal #5
14. How well do you understand the strategic plan?
- Very Good Understanding
  - Good Understanding
  - Some Understanding
  - Poor Understanding
  - Very Poor Understanding
15. In your opinion, will the new strategic plan affect employees at George Pearson Centre?
- Yes (If you answered "Yes", go to question 16)
  - No (If you answered "No", go to question 17)
  - Unsure (If you answered "Unsure", go to question 17)
16. In your opinion, what effect will it have on employees?
- 
- 
- 
- 
17. When did you first hear about B.C. Rehab's Strategic Plan?
- I had not heard of it before today
  - after the strategic plan was set
  - when the strategic plan was being developed
  - when B.C. Rehab first decided to do a strategic plan

18. Did you have the opportunity to express your opinions about the strategic plan?

a. Yes (If you answered "Yes",  
go to question 20)

b. No  
(If you answered "No",  
go to question #19)

19. Would you have liked  
the opportunity to  
express your opinions?

- a. Yes  
b. No

(Skip questions 20 - 24,  
Go to question 25)

20. When were you given the opportunity to give your  
opinion?

- a. After the strategic plan  
had been approved  
b. When the strategic plan was  
in the development stages  
c. Unsure

21. Did you take the opportunity  
to give your opinions?

- a. Yes (If you answered yes,  
go to next question)  
b. No  
(If you answered no,  
Skip questions 22,23 & 24;  
Go to question 25)

22. How did you communicate your opinions?  
**CIRCLE** As Many As Appropriate

- a. discussions with my manager  
or supervisor  
b. in meeting(s) called by management to discuss  
the new plan  
c. as part of a strategic  
planning working group or  
committee  
d. in writing as part of a  
report or brief  
e. Other: (please specify)

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23. How comfortable did you feel about giving your opinion?

- a. Very comfortable
- b. Comfortable
- c. Neutral
- d. Uncomfortable
- e. Very uncomfortable

24. How seriously would you say your opinions were taken?

- a. taken very seriously
- b. taken seriously
- c. were not taken seriously
- d. not taken at all seriously
- e. unknown

25. In your opinion, do staff accept the strategic plan?

- a. Completely Accepted
- b. Mostly Accepted
- c. Neutral
- d. Mostly Rejected
- e. Completely Rejected

26. If you feel the plan is not accepted, why not?

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Now a few general questions. CIRCLE the best answer.

27. How frequently do you usually participate in the decision to hire new staff?

- a. never
- b. seldom
- c. sometimes
- d. often
- e. always

28. How frequently do you usually participate in the decisions on the promotion of any of the professional staff?

- a. never
- b. seldom
- c. sometimes
- d. often
- e. always

29. How frequently do you usually participate in decisions on the adoptions of new policies?
- a. never
  - b. seldom
  - c. sometimes
  - d. often
  - e. always
30. How frequently do you participate in the decisions on the adoptions of new programs?
- a. never
  - b. seldom
  - c. sometimes
  - d. often
  - e. always

The next few items are about working at George Pearson Centre. Circle the answer which best describes your feelings.

31. There can be little action here until a supervisor approves a decision.
- a. Definitely false
  - b. False
  - c. True
  - d. Definitely true.
32. A person who wants to make his or her own decisions would be quickly discouraged here.
- a. Definitely false
  - b. False
  - c. True
  - d. Definitely true
33. Even small matters have to be referred to someone higher up for a final decision.
- a. Definitely false
  - b. False
  - c. True
  - d. Definitely true
34. I have to ask my boss before I do almost anything.
- a. Definitely false
  - b. False
  - c. True
  - d. Definitely true
35. Any decision I make has to have my boss's approval.
- a. Definitely false
  - b. False
  - c. True
  - d. Definitely true

Don't give up. Only one more question to go! Please take your time and answer as fully as you can. Use the back of the page if you need more space.

36. In your opinion, are there concerns which must be addressed by administration before the strategic plan can get started?

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Any additional comments that you would like to make?

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Thank you so much for your time. You may use the envelope provided to return this questionnaire through the Centre's mail system.

If you wish, you may leave your questionnaire in my mail basket located in the social work department.

Any questions or comments?

Call me, Nancy Clay, at 321-3231, local 781, or  
Dr. Sharon Manson-Singer, 822-3251.

Again, thank you for your assistance in this project.

APPENDIX C

Letter of Permission  
Reprints & Permissions  
The American Sociological Association

# the american sociological association

1722 N Street NW, Washington, DC 20036

phone: (202) 833-3410

fax: (202) 785-0146

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Scale of Personal Participation in Decision Making and Hierarchy of Authority

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MW

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Date

APPENDIX D

Letter of Agency Approval  
British Columbia Rehabilitation Society



November 30, 1992

Behavioural Sciences Steering Committee  
The University of British Columbia  
Vancouver, B.C.

TO WHOM IT MAY CONCERN

Re: Research Proposal - B.C. Rehab Strategic Plan

The above noted research proposal submitted by Nancy Clay has been reviewed by senior staff of the B.C. Rehabilitation Society. This review has consisted of a number of interviews with Ms. Clay as well as an examination of a number of draft documents.

The B.C. Rehabilitation Society approves this research project subject to final approval by the appropriate committees at U.B.C., including the Ethical Review Committee.

Yours truly,

W.G. Fraser  
President/C.E.O.

WGF/jh

APPENDIX E

Certificate of Approval  
Behavioural Sciences Screening Committee  
Research and Other Studies Involving  
Human Subjects

The University of British Columbia  
Office of Research Services

B92-002

BEHAVIOURAL SCIENCES SCREENING COMMITTEE FOR RESEARCH  
AND OTHER STUDIES INVOLVING HUMAN SUBJECTS

C E R T I F I C A T E of A P P R O V A L

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INVESTIGATOR: Manson Willms, S.  
UBC DEPT: Social Work  
INSTITUTION: Hospitals;VSB  
TITLE: Class project: Student projects for SW 551  
NUMBER: B92-002  
APPROVED: FEB 4 1992

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The protocol describing the above-named project has been reviewed by the Committee and the experimental procedures were found to be acceptable on ethical grounds for research involving human subjects.

*ROR* Dr. R.D. Spratley  
Director, Research Services  
and Acting Chairman

THIS CERTIFICATE OF APPROVAL IS VALID FOR ONE YEAR  
FROM THE ABOVE APPROVAL DATE PROVIDED THERE IS NO  
CHANGE IN THE EXPERIMENTAL PROCEDURES

APPENDIX F  
Pre-test of the Measure

**APPENDIX F**  
**PRE-TEST OF THE MEASURE**

The questionnaire was pre-tested by two B.C. Rehab employees employed at another B.C. Rehabilitation Society facility, G.F. Strong Rehabilitation Centre. Pre-test participants were asked to provide feedback on format, clarity of instructions and timing. As a result of participant feedback, the instrument's format was amended for clarity. The wording of some directions was simplified and made consistent throughout the instrument. As well, confusing wording in one question (#36) was corrected.