Innovation and Leadership in a Mental Health Facility

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For 3½ years an occupational therapist persevered in efforts to introduce an innovative outpatient service of multidisciplinary team case management within a general community hospital. The service was intended to meet the needs of discharged clients with severe mental illnesses who were attempting to live successfully and satisfactorily in the community. The reality of attempting to initiate change in medical bureaucracies involves ongoing negotiation and persuasion, issues of power and politics, differing cultural visions, and strongly committed leadership. This case study describes the developmental process of innovation and the contribution of occupational therapy philosophy and practice to the therapist’s emergent leadership in promoting cultural change. Some of the lessons to be learned from this case study by others who would attempt institutional innovation include articulating a clear vision that uses new language, building coalitions, and being flexible and persistent.

This article presents a case study description and analysis of the long negotiation process of implementing change in services and service delivery for clients with severe mental illness who were outpatients of an acute care psychiatric unit of a general hospital. The change—the formation of a multidisciplinary team to provide ongoing, coordinated care—was proposed and negotiated for by an occupational therapist.

The purpose of this article is to reveal and interpret the developmental process involved in seeking to make organizational, program, or service changes in medical bureaucracies. At a time when health services are in a state of change or flux in terms of demands from the public and funders, it seems useful for providers of mental health services to be aware of and prepared for the delays and roadblocks they may encounter as they attempt change. Such understanding may support the change-makers in maintaining the perseverance that is often required to achieve successful innovations.

This case study is one component of an extended ethnographic research study, conducted by the author between 1983 and 1989 in a medium-sized Canadian city, of the evolution of an outpatient clinic for clients with schizophrenia. Although the events described in this article took place more than a decade ago, a current ongoing research study of an attempt at introducing a new rehabilitation service in a large provincial psychiatric hospital (analogous to state psychiatric hospitals in the United States) reveals that similar processes of development are occurring. That is, although the context of events in terms of time and place are different and thus one cannot generalize the results of the 1980s study, it does appear that the processes themselves and the analysis of those processes meet the criterion of “transferability” (Lincoln & Guba, 1985, pp. 297, 316) to situations where health care professionals are attempting to introduce new services. Case study analysis of organizational change may offer lessons that can assist those who wish to be leaders of innovations in programs and interventions in health care.

The process of innovation that is described here occurred before participant observation at the site began. The history was obtained from an analysis of all available documentation of the process and in-depth, tape-recorded and transcribed interviews with key participants including the occupational therapist; the directors of the departments of psychiatric services, social work, psychology, and day care therapy; and all the members of what became known as the Schizophrenia Clinic Team. The history of the process is, therefore, a reconstructed account based on the participants’ memories as well as written reports and minutes of meetings. The sequence and description of events were consistently reported by the above named informants and supported by the written sources. The criterion of credibility for qualitative studies (Krefting, 1991; Lincoln & Guba, 1985) would thus appear to be partially met by the triangulation of
sources and the later prolonged engagement and my ob-
servations at the site. In addition, this reconstruction was
read and supported by three of the participants in the
study, thus providing the “member checks” that Lincoln
and Guba (1985, p. 314) recommended as another tech-
ique to enhance the credibility of findings.

This article is organized in two parts. Part I provides a
chronological description of the process of initiating
change in mental health services and an analytic under-
standing of the difficulties in implementing new pro-
grams of care. Part II examines the role of leadership in
fostering change and the contribution of professional ide-
ology to the commitment to effecting change.

Part 1: The Developmental Process of Innovation

The Context for Change

By the late 1970s, the neglect and seeming abandonment
to the streets of deinstitutionalized persons with chronic
mental illness was being described in professional jour-
nals, exposed in the popular press, and examined by com-
missions of inquiry (Bachrach, 1983; Cook, 1988).

Some of the professional staff members in the Psychiatric
Services Unit of the hospital described in this case study
were increasingly concerned about the lack of programs,
coordination of services, and even the availability of ac-

Me: At that point the treatment of schizophrenia was done on an

individual basis. Therapists and psychiatrists were working inde-

pendently. There were no formal mechanisms for coordinating

treatment. Individuals who were really ill could quite easily have

as many as four therapists. So you had multiple therapists but no

mechanism for coordinating. If you had a concern or problem or

you wanted to clarify something, you tried catching the psychia-

trist in the breakaway or coffee lounge or in the hall. It was a free

flow, spontaneous system. It had a rather humorous sound to it, but in

fact, with the nature of schizophrenia and the kinds of

multiple problems that our clients had, for myself and for other

people it was very ineffective and at times dangerous. Crisis inter-

vention was almost impossible because there was no unified ap-

proach as to how the case was going to be handled. You really
didn’t have the opportunity to discuss the outpatient approach
with the psychiatrist or other staff, so it was really challenging.

On a more global level, Psychiatric Services had no unified

concept of how we were going to treat schizophrenia. Some peo-

ple used a medical approach, some people used a psychological

approach, some people used a supportive centered approach, some

humanistic, and there were even people who had a more

layman approach. So we had a lot of problems. People were

coming from different angles and there was no opportunity for

collaboration. Clients were not being informed or educated about

their illness. They often had very poor compliance with treatment

as a result. There was a revolving door that was incredible. People

would be hopping in and out—I’m talking about the more seri-

ously ill. We had what we called the “lounge crowd” of young

schizophrenics that would hang around the hospital and smoke

and drink coffee. They had no sense of direction, but it was more

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The terms client and patient were used interchangeably by the Clinic

staff members, although client had become the preferred term by the

conclusion of this study.

symptomatic of the problem that they had.

Families were blamed for the illness. A lot of families became

very distressed. I received numerous calls and letters from parents

wanting help. At that time people were actually being referred to

Social Work to be assessed to see if family pathology was causing

the illness.

The starting point, really, for us were the patients, their fami-

lies, and their needs. And the needs were multiple. Several clinici-

ans and representatives from all disciplines were really con-

cerned about the situation and really wanted to improve our

aftercare for, at that point, what we called “the chronic popula-

tion.” And the result of that was informal meetings.

By 1980, the environmental pressures for improved

and more available services to deinstitutionalized clients

were increasing. The members of the newly formed local

chapter of the Friends of Schizophrenics (an organization

similar to the National Alliance for the Mentally Ill [NAMI

in the United States) were requesting professional help

for their ill relatives and for themselves. The physicians,

both general practitioners and psychiatrists, at the hospi-
tal were also finding the increasing numbers of persons

who were chronically ill a demanding responsibility due

to the multiple social and functional problems with which

these clients presented. The revolving door problem, cri-

sis episodes, and the lounge crowd worried the hospital

administrators.

The First Initiatives: 1979–1980

In the late months of 1979, one of the psychiatrists began

to feel overwhelmed by the pressure of the large caseload

of patients with schizophrenia that he was carrying:

I had reached the stage where I couldn’t go any further. I
couldn’t handle it. There wasn’t sufficient backup...there was a
steady increase year by year...So at that time I presented a
seminar, at one of Friday morning in-services [in-house education
series] on the problem of schizophrenia. I became convinced that
we had to do something about it.

A small group of clinicians, including the occupational

therapist, a social worker, and a nurse who were also

concerned about the lack of coordination and follow-up

of outpatients, began to meet once a week for short pe-

riods with this psychiatrist to discuss these issues in regard
to his patients. In late May 1980, the occupational thera-

pist wrote a memo to her department manager outlining

in considerable detail the need for and benefits of a for-

designated, multidisciplinary, outpatient team for

the coordination of services for the chronically ill who

required continuing care (see Appendix A). The combina-

tion of the psychiatrist’s inservice, the occupational

therapist’s memo, and the visit of a British psychiatrist

who pointed out the inadequacies of care for this specific

population led the Director of the Psychiatric Services to

bring the issue before the Professional Advisory Com-

mittee for Psychiatric Services (PAC). This body met monthly
to plan, approve, and evaluate services and programs. It

was composed of department chiefs or managers from

the various disciplines and hospital administration. Three

months later, a Task Force on Continuing Care, chaired

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by the Chief of Social Work, was convened to define the current needs of the chronic population, to establish their future needs for programs, and to submit a report by the end of the year.

The Initial Negotiations: August 1980–March 1982

The task force included the clinicians who had been meeting weekly with one psychiatrist and other department chiefs and representatives. The task force met regularly for 8 months and then held a 2-day workshop in an attempt to reach consensus on how to proceed with its mandate. The divisive issue was whether a program should be established to provide care for a small number of the most obviously disabled, clearly defined, chronic, users of resources (the position of the Chairperson of the task force) or whether a service only for patients with schizophrenia, both newly diagnosed and chronic, should be undertaken (the psychiatrist’s position).

In the minutes of the PAC meeting of May 11, 1981, the Chairperson of the task force is reported as stating that “after nine months of work the Task Force was grinding to a halt.” One month later he reported that, although some short-term goals, such as establishing a list of needy patients, had been met, the problem of defining the population to be served was at an “impasse situation” and would probably require resolution by PAC. On October 26, 1981, PAC requested recommendations from the task force for review. In December 1981, the Chairperson of the task force submitted to PAC a “majority proposal for a continuing care program for chronic psychiatric patients” which was to begin with a modest caseload of 32 patients who would be provided with the services of a multidisciplinary team. The report was tabled for several months until the psychiatrist’s minority report favoring the establishment of a program for patients diagnosed as having schizophrenia was presented to PAC on March 8, 1982.

The minority report contained indications of the problems and conditions encountered by those who had such high hopes for the policy of deinstitutionalization and to which the occupational therapist was responding in recommending a team-coordinated service. As Cameron (1978) had written, “the severely mentally ill, on the other hand, are more professionally frustrating; treating them has been largely eschewed with the reorganization of the health system” (p. 323). The minority report outlined the reality of practice, which had resulted in many persons with chronic mental illness suffering from neglect in the community:

If we are drawing up a program covering all types of chronic mental illness, then I would see no special role for a psychiatrist in the program apart from what is happening now. We would be dealing with very much the same patients we have around the unit now and each of them are [sic] under the care of a psychiatrist. I am unclear as to how we could develop a meaningful program for these patients because most of them are really just being carried and there is not too much hope for therapeutic improvement. I feel it will be difficult to find a psychiatrist who would devote himself to the chronic care program as envisioned by our committee, because it would soon become a dumping ground for patients who are really untreatable. On the other hand it might be possible to find a psychiatrist for an active and interesting schizophrenia program, which I think is much more important for this area.

After much discussion, a compromise motion was offered to PAC: “that the various individuals from departments involved meet to establish a team to begin dealing with chronic patients – specifically schizophrenic patients – in a formalized fashion.”

Planning the Schizophrenia Clinic: April 1982–December 1982

The members of what was designated as the Continuing Care Team first met in April 1982. The membership included the original members of the group who had been meeting regularly with the psychiatrist and representatives from the Day Therapy and Nursing Departments. The director of the Psychiatric Services Department asked the occupational therapist to be the chairperson of the team meetings. In June 1982, after three meetings, the chairperson submitted a report on the team’s progress, which included issues of patient identification, the development of a registry system, and a preliminary model of team functioning in regard to coordination of treatment and review of patients’ progress. The team continued to meet once a week for 1 hr. In a transcribed interview the therapist-chairperson described the process that led to the proposal for a Schizophrenia Clinic:

We looked at the schizophrenic clients we were working with that had problems and we studied them all in depth and we made lists of patients and worked out what themes were emerging. The whole process was really unsatisfactory because all we were doing was studying, but in the meantime our clients were still having problems and nothing was happening. So, finally the team got frustrated and decided what we really needed was a team approach for starters and we needed good case management. That was what was emerging from the discussions. So we decided that the best approach would be to develop a schizophrenia clinic and (the psychiatrist) actually called it ‘The Schizophrenia Clinic’. That’s where the beginning for that concept came from.

In December 1982, a formal proposal written by the occupational therapist–chairperson was submitted to PAC (see Appendix B). The proposal reflected all the concerns expressed in her May 1980 memo, but now they were more specifically detailed in terms of establishing a schizophrenia clinic that would meet the “combined needs of psychiatrists, other professional staff, the patient, his family and community agencies.” The proposed clinic format retained the private relationship of psychiatrists to their clients but gave them each a block of time to meet with the multidisciplinary team to discuss their roster of clients and plan for the coordinated delivery of services.

Resistance to and Acceptance of the Plan: January 1983

At the January 1983 meeting of PAC, the Chief of Social
Work (and former Chairperson of the task force) in a written memo and in person at the meeting, criticized the schizophrenia clinic proposal in terms of its scope, staffing, and program design. He argued persuasively for the development of "a quality service for a smaller number of chronic patients [rather than] diffusing our efforts hy psychiatric Services and in that capacity now attended PAC meetings. As she listened to the arguments against the proposal she told me that she began to "feel desperate." She was sure PAC would turn down the proposal and ask for the development of a program or programs for a population (rather than establishing a clinic format with team input to meet the needs of individuals); then the whole process would go back to the beginning and it would take another 2 years or more to reach any decision. She said, "As an [occupational therapist] I have started a lot of new programs here and I know that approach doesn't work." Her feeling of desperation was also influenced by the recent suicide of one of her clients. She believed that the death might have been prevented had the clinic concept been realized, so she argued "that if we could just start with good case management even though we didn't have a lot of resources, then at least we would be making some inroads and giving it a start." After much discussion, PAC agreed – with the proviso that the Clinic Team develop a program proposal to be submitted to the District Health Council for independent funding. The departments of social work, day therapy, and occupational therapy each agreed to give 6 hr of staff member time per week to the clinic.

The occupational therapist and the social worker on the Continuing Care Team were asked to write the proposal for additional funding, within some severe limits imposed by PAC members and particularly by the Director of Psychiatric Services. They were told to keep the proposal modest and to only request funding for a half-time social worker and half-time nurse. (The original plan from the Continuing Care Team included additional day therapy and occupational therapy staff.) PAC believed that the existing services with their 6-hr per week commitment were adequate. In addition, the Director believed that there was a greater chance of securing funding if the proposal was small.2

The occupational therapist reported that she fought and advocated for increased occupational therapy involve-

2Ironically, the Director explained to me in an interview that he had been mistaken. In fact, the Ministry of Health totally funded as requested all proposals ranked number 1 and 2 by the District Health Councils. The Schizophrenia Clinic proposal was ranked number 1 and thus could have received much larger funding. The lack of adequate funding was a source of many subsequent problems in the Clinic's development.

The application for funding had to be submitted only 2 weeks after PAC approved the clinic proposal. Many unpaid, overtime hours were spent in completing the forms required by the Ministry of Health guidelines. At the last moment, the Director of Psychiatric Services agreed to include a request for additional occupational therapy time but not for day therapy time. With the exception of the staffing requests, the proposal submitted (see Appendix C) was, in essence, the same program proposed in the submission to PAC, which itself was very similar to the multidisciplinary team concept proposed in the original memo sent by the therapist to her department manager (see Appendices A and B).

The Implementation of the Clinic—March 1983

The psychiatrist from the Continuing Care Team was appointed as the Director of the Schizophrenia Clinic, and the occupational therapist was given the informal title of Team Coordinator (i.e., responsibility for day-to-day administration of the clinic but without administrative authority).

The first formal case conference clinic was held in March 1983 before funding was approved. By September 1983 the occupational therapist in her role as Team Coordinator had, by persuasion, letters, and memos, convinced all the psychiatrists who had a roster of clients with schizophrenia to schedule regular clinics with the team. In October 1983, the provincial Ministry of Health granted the program funding for a trial period of 2 years, with permanent funding dependent upon two annual Ministry evaluations. It was the first schizophrenia clinic in Canada. There were various service programs (such as vocational assessment and training, social skills groups, and activities of daily living groups) throughout the country at that time but no multidisciplinary clinics offering individualized, client-centered, case management to a population with a specific condition.

This process of innovation took more than 3 years to reach fruition. In the late 1960s, when deinstitutionalization was well under way, a critical account of the problems faced by workers in mental health facilities reported that "innovative thinking has been encouraged, while innovative action has been resisted" (Graziano, 1969, p. 10). Similarly, almost 20 years later Kiniston pointed out that "getting new ideas into the health system and properly used is a long term effort" (1983, p. 1163). As the narrative above illustrates, the idea for a multidisciplinary team service for the persons with severe mental illness took several years and a great deal of effort to reach implementation. An understanding of the obstacles and barriers to
innovation in mental health care requires an exploration of the realities of bureaucratic organization, of cultural differences in the health professions and practices, and of differences in power between interested stakeholders.

Understanding Obstacles and Barriers to Innovations in Health Care

A useful framework for summarizing the process of initiating this innovation is Tichy's (1981, 1983) conceptual scheme of problem cycles. He stated that there are three systems in mutually influencing relationships in any organization: the technical, the political, and the cultural. Any organization has

three basic dilemmas the technical design problem social and technical resources must be arranged so that the organization produces some desired result the political allocation problem allocating power and resources who will reap benefits and the ideological and cultural mix problem to determine what values need to be held” (Tichy, 1981, p. 165).

In very simplified terms, what occurred during the developmental process described here can be conceptualized as follows: There was a technical problem—the provision of services to a new clientele, the deinstitutionalized client with chronic illness; the proposed solution to this technical problem involved cultural change in values, practices, and organizational structure; the cultural change proposal became the focus of political negotiation, challenge, and opposition. Each of these waves of activity took place within a medical bureaucracy in a time of changing social and political approaches to persons who were mentally ill. These varying cycles, contexts, and historical circumstances were intertwined in the long process that eventually led to the adoption of the innovative change.

The Reality of Barriers to Innovation Within a Bureaucracy

Many of the propositions developed by Downs (1967) on the problems of change in bureaucracies were borne out during the ongoing negotiations for the initiation of the Schizophrenia Clinic. For example, Downs stated that in large bureaucracies “nearly every major structural or behavioral change is preceded by study of the need for such a change carried out by one or more committees” (1967, p. 275). The 3 years required to implement the original idea proposed by the occupational therapist can be partially explained by the barriers posed to innovation in bureaucracies. The appointing of committees, then a task force, then a workshop, then a feasibility team, and so on, each needing approval from yet another layer of the hierarchy, bogged down the decision-making process in terms of both time and competing alternative approaches. An additional problem was that this change was initiated from the bottom up in an organization accustomed to directives issued from the top down. Those with the authority to make decisions—the members of PAC—were department and administrative chiefs who were not involved in day-to-day interaction with these clients. Most of those working toward the implementation of a multidisciplinary outpatient service were lower-level staff employees in terms of the hierarchical arrangement of decision making, until the occupational therapist became a member of PAC. The problems of change initiated from the bottom up in a bureaucracy that “can mire staff in a morass of detail and conflict” (Weissman, 1982, p. 44) were evident in this attempt to develop a new service. That is, organizations that are arranged in hierarchical form, with clearly defined departments and professional role definitions, are more likely to require longer time frames for negotiation toward decision making because of the multiplicity of interests, professional practices, and authoritative channels.

The Reality of Cultural Differences in Delaying Consensus

Morgan (1986) identified another important factor in understanding the process of change in organizations. “Traditionally the change process has been conceptualized as a problem of changing technologies, structures and [people] . . . [but] . . . effective change also depends on changes in images and values that are to guide action . . . organizational change implies cultural change” (pp. 135–138). Some of the delays encountered in developing the Schizophrenia Clinic resulted from a dispute over values and behavioral solutions. The opposing proposals from the Chairperson of the task force and the Continuing Care Team chaired by the occupational therapist illustrate the cultural diversity. One proposed defining the problem as a question of use of services and the need to establish group programs for the chronic users of such services. The other proposed an individualized, psychiatrist-team-directed, direct service delivery to a more clearly identified population in need of specialized services. These were different philosophies of intervention, evidenced different values as to the neediest population, and proposed different professional responses as a solution.

The emergent solution for a case management service took many months of cultural defining work by the Continuing Care Team. This process was not just one of innovation but one of fundamental cultural change. The focus of practice was to be on the community and the clients who lived there, rather than on inpatient care. The approach was to be individualized, coordinated services to the client and family, not the provision of group programs. The services were to be integrated, comprehensive, and coordinated by a collaborative and overlapping team, rather than fragmented, technical expertise provided by several departments. The primary goal was rehabilitation (maintaining and enhancing function), not
treatment to effect cure. The new service was designed to provide continuing after-care, not short-term, acute care.

Although the cultural solution among the members of the Continuing Care Team evolved through consensus, its eventual adoption depended on the ability to mobilize support for the proposal within the hospital. Both the delayed nature of this innovation process and the eventual adoption were influenced by political activity and differential access to power.

**The Reality of Power and Politics in Negotiating for Change**

In their classic work on psychiatric institutions, Strauss, Schatzman, Bucher, Ehrlich, and Sabshin (1964) conceived of the institution as an arena of negotiation and the eventual working structure and practices as a negotiated order. Several illustrations of the negotiating process culminating in the Schizophrenia Clinic have been provided. However, the process of negotiation was not between equals in each context. The adoption of the proposal depended on the ability to mobilize the power resources within the hospital.

As Kanter (1983) pointed out, there is a “political side to innovation... it requires campaigning, lobbying, bargaining, negotiating, caucusing, collaborating and winning votes. That is, an idea must be sold... and [there is a need] for power to turn ideas into action” (p. 216). Or as Graziano (1969) so cogently put it, “the conception of innovative ideas in mental health depends upon creative, humanitarian, and scientific forces, while their implementation depends, not on science or humanitarianism, but on a broad spectrum of professional and social politics” (p. 10).

Traditionally, in mental health facilities, decision-making power is vested in the medical profession, department heads, and top administrators. In this hospital, the decision-making body was the P&O composed of such persons. Initially, neither of the two prime movers for the innovation (the psychiatrist and the occupational therapist) was a member of this body. It was only at the end of the process, by virtue of a promotion, that the occupational therapist was able to attend the meetings and lobby for the adoption of the clinic proposal. Occupational therapists as a group have traditionally held less powerful positions among medical professionals. Maxwell and Maxwell (1977) attributed this lack of power to the history of medical sponsorship and hence control of occupational therapy, to the diffuse and not-well-understood expertise of its practitioners, to its association with chronicity and rehabilitation rather than the more dramatic acute-care medical practice, and to its being a predominantly female profession. This lack of power has led to a pattern of adaptation to the health care hierarchy that was characterized as “diffidence” by Maxwell and Maxwell (1977, p. 83).

Perhaps, in this case, the occupational therapist’s “diffident” pattern of lobbying for support by writing memos and being part of the task forces and committees, but being unable to directly participate in the decision-making level of the hierarchy, partially accounts for the length of time it took to finally implement the original idea. In spite of being able to secure the support of the Director of Psychiatric Services, the innovation was almost lost due to the skilful, persistent, and, as later events proved, prophetic opposition of the Chief of Social Work who served as the Chairperson of the initial task force. As Downs (1967) pointed out, opposition to change is more likely to occur when the change will reduce the resources one has to control and decrease the importance of the functions currently fulfilled. The proposed clinic format would be under the control of the medical profession. The opposing proposal for group programs would have provided opportunities for an expansion of Social Work jurisdiction and, hence, control. The detailed critique of the clinic proposal in terms of its inadequacies in design, goals, and resources almost blocked the innovation. In the end, the proposal was approved because it met the interests of those who had control over the decision—the psychiatrists and the hospital administrators. The former would get the support services they needed and the latter could be seen to be providing further community service (which, in their interest, also resolved the lounge crowd nuisance and the revolving door problem) but at a low cost because the program was to be funded by an external grant from the Ministry of Health. The power brokers had to be convinced that it was in their interests to approve the program. The length of time required for the lobbying, persuading, and stating the case that the occupational therapist pursued was prolonged by political opposition from those who had something to lose or nothing to gain if her innovative idea was adopted.

**Persistence and Innovation: Professional Values and Cultural Leadership**

This chronology of the process of effecting an innovation in the delivery of mental health services illustrates the lengthy negotiations, persuasion, meetings, and discouragements faced by those who would initiate change in medical bureaucracies. This chronology makes understandable those situations in which service providers give up their attempts to improve service delivery. Why, in this situation, did an occupational therapist persevere to institute this innovation? What enabled her to persevere in spite of setbacks, delays, and opposition? In part II of this case study, some possible answers to those questions are

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explored. The thesis to be argued is that the philosophy (values and beliefs or professional ideology) adhered to and the professional practice experience of the primary change agent were important personal resources and stimuli for leadership activities.

Part II: The Role of Professional Ideology in Leadership and Cultural Change

Kanter (1983) described those who effect change or innovation as entrepreneurs. She wrote “entrepreneurs are above all visionaries. They are willing to continue single-minded pursuit of a clearly articulated vision, even when the line of least effort or resistance would make it easy to give up” (p. 239). What enabled the occupational therapist in this case study to continue pushing for change while others gave up the fight when consensus could not be reached? What can account for the eventual acceptance of her original proposal for an outpatient multidisciplinary team? Why did she emerge as the informal leader of a cultural change and its eventual implementation? One possible interpretation is that her professional affiliation and experience as an occupational therapist provided her with the beliefs and values (professional ideology) that were used as personal resources for initiating change.

The Nature and Function of Professional Ideologies

Wilson defined ideology as

a set of beliefs about the social world and how it operates, containing statements about the rightness of certain social arrangements and what actions would be undertaken in the light of those statements. An ideology is both a cognitive map of sets of expectations and a scale of values in which standards and imperatives are proclaimed. Ideology thus serves both as a cue to understanding and as a guide to action, developing in the mind of its adherents an image of the process by which desired changes can best be achieved (1973, pp. 91–92).

Similarly, Marx characterized the ideology of a profession as a “morally charged mandate for action” (1969, p. 81). The literature on organizational life cycles and organizational culture examines the importance of ideology as a resource in creating new meaning in innovative activity, to legitimate those activities and to develop an identity or ethos that provides direction and purpose (Abravanel, 1983; Lohdahl & Mitchell, 1981; Smircich, 1983). Thus, the primary function of ideology is prescriptive.

If ideology provides the stimulus to action, one can presume that when innovative activities are proposed within an organization, there is a different ideology underpinning those proposals. Ideology becomes a central feature of the innovative organization. The ideology summarizes the values and ideals that the founders intended the new organization to epitomize by using the ideology as a resource. The founders may be able to generate commitment and value consensus. (Lohdahl & Mitchell, 1981, pp. 186–187)

The adherence to ideological values can serve to attach meaning to situations and the actions required within them. Those meanings and prescriptions for action are the resources of those who lead cultural change.

The Role of Leadership and Shared Meaning in Innovation: The Cultural Connection

In an analysis of leadership, Smircich and Morgan (1982) stated:

Leadership is the Management of Meaning. Leadership is realized in the process whereby one or more individuals succeed in attempting to frame and define the reality of others. They emerge as leaders because of their role in framing experience in a way that provides a viable basis for action. (pp. 257–258)

Schein (1985), in an analysis of cultural change in organizations, declared that

as I began to think through the issues of how culture changes, I again realized the centrality of leadership—the ability to see a need for change and the ability to make it happen. Much of what is mysterious about leadership becomes clearer if we link leadership specifically to creating and changing culture. (pp. 38–39)

Hall (1982) defined leadership as being “what a person does above and beyond the basic requirements of his [sic] position. It is the persuasion of individuals and innovativeness in ideas and decision making that differentiates leadership from the sheer possession of power” (p. 161). Bennis (1979) expanded this definition by stating that “leadership involves more than managing, more than just being an idea man [sic], it involves questioning the routine” (p. 42). There are three requisite characteristics for determining leadership or change agent implied in the foregoing quotations: (a) the ability to recognize the need for change; (b) the ability to define, create, or develop meaningful realities or bases for action to meet the need; and (c) the capacity to mobilize resources to implement the change.

The occupational therapist in this case study went beyond the mere requirements of her job, questioned the routine modes of therapeutic practices with persons with chronic mental illness, and proposed an alternative reality of service. In proposing a new service, she was introducing a different ideological system of beliefs, that is, a different cultural frame for practice. Both the psychiatrist and the occupational therapist on the Continuing Care Team saw a need for change in the after-care services for clients with chronic mental illness. The psychiatrist defined it in terms of requiring support services from others:

[T]o treat patients with schizophrenia is a lifetime job; the social problems are so great. It seemed to me that the psychiatrists would be willing to treat schizophrenics if they got support. Just as I was prepared to treat them if I got support.

On the other hand, the occupational therapist had defined the need in terms of ongoing, individualized client care that required the coordination and integration of services and workers by enhancing communication.
through a formally structured team mechanism. Both professionals worked toward defining the situation, but from different perspectives. With the exception of his minority report to PAC, the psychiatrist did not participate as actively in the various task forces and meetings as did the occupational therapist, nor did he outline in writing the kind of detailed proposals supported by treatment principles that the therapist continuously circulated (see Appendices A and B). These various written memos and proposals documented the therapists’ vision of service (Bennis, 1979) and they began to establish a meaning structure as the basis of action.

It is the third requisite that most distinguished the occupational therapist rather than the psychiatrist as the primary change agent and emergent leader. Kanter (1983) stressed “the link between individual entrepreneurs and their coalitions or teams. Individuals initiate . . . and then work through teams to bring ideas to innovation. Prime movers push—by getting more and more people involved in action vehicles that express the change being promoted” (p. 35). Because of her participation in the various task forces and committees and her appointment to PAC and chairmanship of the Continuing Care Team, the therapist slowly gathered support from others who came to share her definitions and they, through interaction, began to develop shared understandings of the need for and type of change required.

It is “shared meanings that permit organized activity to emerge and assume coherence . . . for unless meanings are in some sense shared, there can be no alignment and coordination of action” (Morgan, 1984, p. 315). The occupational therapist described the final consensus on meaning in terms that confirm Louis’s (1983, p. 50) statement that: “A key premise of a cultural view is that meaning is emergent and intersubjectively negotiated.”

We decided what we needed was a team approach, for starters, and we needed good case management. That was what was emerging from the discussions. With the problems we had, we had to start with the clinic, the team, and case management. That was the only logical place to start, but interestingly enough that took a long time to evolve—that concept. It seems so obvious when you look at it, but it wasn’t obvious when we were groping with the start. At one point people were looking at starting a program here in the hospital—a social program, a work program, etc.—and that would have been putting the cart before the horse. You can’t rehabilitate on that basis.

The ongoing consultations in weekly meetings and the written proposals on goals, objectives, and rationales prepared by the occupational therapist were instrumental in bringing the clinic to being, for, as Kanter (1983) stated, “prime movers push in part by repetition” (p. 296). In the midst of the ambiguity and ad hoc nature of the 3-year process of initiating the multidisciplinary clinic idea, the therapist’s written proposals provided some structured meaning even as they were being negotiated.

However, as Schein (1985) contended, “cultures do not start from scratch. Founders and group members always have prior experience to start with” (p. 221). This insight on prior experience leads to questions about the content of the ideology underpinning the innovation known as the Schizophrenia Clinic.

Professional Ideology as a Resource in Promoting Innovation: The Values of Occupational Therapy

In 1986, 3 years after the clinic was established, the occupational therapist provided for some new members of the team what she termed a historical review of the clinic development in the following words:

[My] purpose is to provide some information about the clinic’s development, to help us regain, or for the new people, to gain an understanding of our philosophy, central concepts and organization. . . . What I’m wanting to highlight through this review is that there are certain central concepts that are important to the clinic. Number one is that we are client centered. We are looking at the client first and administration second. Now that is why the program was established. Secondly, that we wanted to look at the development of a holistic, coordinated approach. As we all know, individuals with schizophrenia have a multiplicity of problems and really require a team effort. When you look at the clinic, each member of the team has a very specific role. There is some overlap, but there are so many things to look at, that a team effort is required. Along with the team approach is the understanding that the clients are going to relate to a team, not just one individual. So if someone leaves or is sick, or on holiday, that client doesn’t feel like he has no one to relate to—they have got a team. The third concept is that schizophrenia is a mental illness and that informing clients and their families about the diagnosis is important and that education is really going to facilitate community adjustment. Along with that concept is our feeling that client participation in their treatment and taking responsibility is important. The fourth is case management and the importance of good linkage between the community and the hospital resources and really helping the client to make the links and have access to that. A final point that is essential to clinic functioning is that it is a point of contact for clients, community, and staff.

Most occupational therapists reading the above quotation will recognize the description of the Schizophrenia Clinic as an embodiment of many of the fundamental beliefs, values, and principles of practice of the profession. The writings of many of those honored by their profession with the Eleanor Clarke Slagle Lectureship in the United States (American Occupational Therapy Association, 1985) or the Muriel Driver Lectureship in Canada (Baptiste, 1988; Carswell-Opzoomer, 1990; Judd, 1982; Law, 1991; Polatajko, 1992) and the Canadian publication on Guidelines for the Client Centered Practice of Occupational Therapy (Canadian Association of Occupational Therapists, 1991), among others, espouse those central values and beliefs of occupational therapy that Yerxa has stated “speak to vital human needs and ensure that people with chronic conditions will be able to lead satisfying, productive lives instead of being throw away people in tomorrow’s world” (Yerxa, 1993, p. 2).

Smith (1984) has advised that those who would attempt organizational change must provide a new language, as the old language maintains the old ways. In contrast to the traditional language of psychiatric prac-
tice, there are different conceptions for services illustrated in this therapist’s historical review and in the documents and proposal for the establishment of the multidisciplinary team clinic (see Appendices A, B, and C): holistic, not specific psychotherapeutic care; clients, not patients; quality aftercare for clients and families, not acute care for the ill patient; case management and education to promote function, not just medical treatment to effect cure; participation of clients and families in treatment planning, not passive reception of service; and coordination of services, not brokerage or fragmentation of expertise.

In focusing her efforts on developing comprehensive services for persons with chronic mental illness, the therapist in this case study also reflected the commitment to those persons often devalued by other professional and lay groups. Yerxa has commented on this essential value of occupational therapy practice:

Otherwise devalued, mental patients were perceived humanistically by the pioneers in occupational therapy as people worthy of dignity—the valuing of a person’s essential humanity in spite of severe and sometimes chronic disease, as central to the practice of the original therapists. The historical values of the profession have been transmitted to modern occupational therapists, as may be seen in current patient advocacy efforts as well as in occupational therapists’ traditional provision of services to the most severely and chronically disabled patients. Such patients are often seen as “beyond help” by many other professionals because of extensive and irreversible pathologies (1983, p. 151).

Perspectives differ on the need for innovation in services for the deinstitutionalized clients in this study, as enunciated by the psychiatrist and the therapist. With the institution of the Schizophrenia Clinic, the psychiatrists gained the back up, supportive services to deal with nonmedical needs of these clients, which were often responsible for their previous neglect by many professionals (Baxter & Hopper, 1982; Cameron, 1978; Cook, 1988; Grob, 1980, 1983; Morrissey & Tessler, 1982). Although one of the premises of deinstitutionalization policy was to provide access to psychiatric care in the community, the resistance to working with this clientele by psychiatrists and some other professionals was unpredicted (Cameron, 1978). The basic needs of persons with schizophrenia are for functional, educational, and supportive services, not the talking therapies that many professionals prefer to offer. Further, the difficulty of working with persons with severe mental illness must not be discounted in understanding the reluctance of many professionals to accept them as clients. Often any progress they make may be small and may take place at a very slow pace. There may be setbacks and relapses and the clients themselves can sometimes be demanding, belligerent, frustrating, and uncooperative (Estroff, 1981; Pranger & Brown, 1992; Price, 1993). In this case the occupational therapist’s commitment to serving the chronically ill was crucial in instigating the long process of improving the services available to them.

Professional Values, Leadership, and Change

The Schizophrenia Clinic as envisioned and, in most respects, as embodied reflected the fundamental values and practice beliefs of occupational therapy to which the therapist in this case study was clearly committed. This commitment appeared to serve as an important driving force in her consistent efforts to realize a vision of improved service. But it has also been noted that leadership requires more than vision and ideas. Successful change masters also require “a longer time horizon, conviction in an idea, no need for immediate results or measure and a willingness to convey a vision of something that might come out a little different when finished” (Kanter, 1983, p. 239).

This process to effect organizational change began with the initiative of a professional in the middle ranks of a hierarchically structured medical bureaucracy. By most accounts such efforts from “the grass roots” (Kanter, 1983, p. 180), the “muddling” middle manager (Feldman, 1980, p. 2) or the “lower level staff change agent” (Weissman, 1982, p. 4) are doomed to failure or as Kanter puts it, “withering” (1983, p. 102). Generally, this lack of success is due to the inability to mobilize resources, particularly political power and support (Graziano, 1969) and due to the general inertia and resistance to change in service bureaucracies (Downs, 1967; Goilembewski, 1985; Kanter, 1983; Kinston, 1983; Mechanic, 1980). In such contexts and circumstances, said Mechanic, unusual leadership is often necessary. A change in direction requires a leader who can communicate to others the sense of excitement in a new venture and who has the organizational skills to bring the necessary people and organizations together. In the absence of a strong incentive—such as available funding—it is extraordinarily difficult to build the necessary momentum (1980, p. 17). Emphasis added.

In spite of the barriers and obstacles to innovation, a leader did emerge who was able to maintain the momentum to eventually put a multidisciplinary team and the clinic together. Her leadership position came about as much by default as by appointment. It appears that by always maintaining the idea of a holistic, multidisciplinary, coordinated, education and case management service she kept the cultural vision in the foreground. The role of defining the reality, of imparting a sense of mission, of creating a new cultural form led to her emergent leadership. As others came to share those understandings and see that it gave purpose and shape to their hopes and working life, her position as unofficial team coordinator solidified. The Schizophrenia Clinic as implemented was a somewhat altered creation but was based nevertheless upon the occupational therapist’s original vision of a multidisciplinary team designed to coordinate services for persons with chronic mental illness.

Much of what we read in professional journals and the popular press documents the powerlessness of so-called lower-level participants to effect change in organi-
izations. In this case, one person did make a difference. A new delivery of services was established that reflected the occupational therapist’s values and beliefs about the importance of client participation, the individual worth of those with chronic illness, the necessity of continuous and ongoing support, the client’s potential for growth, and the recognition of the holistic nature of humans, which requires coordination and integration of services to meet their varied needs. Yerxa (1983) discussed the difficulties and challenges faced by therapists who strive to maintain those values in medically dominated settings:

Owing to the value differences between medicine and occupational therapy, occupational therapists have sometimes had difficulty implementing their values in the traditional medical setting.

Occupational therapy has been sufficiently audacious to create and sustain its own unique model of practice while surviving within, and contributing to, health in the medical milieu. In many respects this persistence of professional values and a singular philosophy, in the midst of conflicting ideals and philosophies, has been trepidly daring (p. 157).

When the therapist in this case was asked why she kept trying for so long to effect change when so many others might have given up, her explanation was somewhat less sophisticated than Yerxa’s, but value-laden nevertheless. She said “the bottom line was improved patient care and that’s what sees you through all this muck.” The profession and its clients need more change making therapists who are so committed to professional values that they “intrepidly” see their way through “all the muck.”

Conclusion: Lessons to Be Learned

Nothing changes quickly. Those who wish to initiate new programs or services within bureaucratic organizations must be prepared to be persistent and persuasive over a long time period.

Have a clear and consistent vision. Change agents are often required to clearly articulate the components of change to many participants in a variety of meetings.

Maintain the vision with new language. In order to change a culture (both the values and the practices) new meaning must be developed through the use of new terminology used consistently when explaining or negotiating for change.

Put it in writing. In this case study, the therapist was the one person who kept the mission in front of others by writing memos and proposals for the change. In turn, those written proposals maintained the vision by reiterating new language.

Build coalitions. Change is much more likely to occur if it is supported by other professionals and administrators. This factor also adds to the time line but is necessary for success in both the initiation phase and the maintenance of the innovation once implemented.

Recognize stakeholders’ interests. This follows from building coalitions. Everyone involved in institutional change has “turf” or professional concerns that can hinder or help the process of change. Being aware of such interests means that adjustments and compromises can be made to change proposals to encourage support.

Be flexible. This follows from the previous lesson. It does not mean compromising the vision for change but allows for the adjustments necessary to build strong coalitions.

Don’t give up or give in. As shown in this case study, initiating change often requires a long term commitment of energy. One’s values can be resources in maintaining enthusiasm. Hold on to them.

Appendix A

Outpatient Multidisciplinary Team Memo (May 26, 1980), Abridged

A team approach would provide a mechanism for:
1. Identifying patient needs, establishing treatment goals, developing and implementing treatment programs
2. Coordinating and integrating treatment programs
3. Providing a systematic review of patient progress
4. Improving quality of care
5. Improving communication among staff and facilitating consistent patient treatment
6. Promoting development of treatment programs based on clearly identified patient needs
7. Maintaining staff morale and impetus in treating this challenging group of patients

Appendix B

Proposal for Schizophrenia Clinic (December 13, 1982), Abridged: Objective and Goals for Clinic

The overall objective of the clinic is to promote the development of good quality treatment services for schizophrenic patients and their families in the community. More specific goals include the following:
1. Provide a formal system for organizing the delivery of treatment care to schizophrenic patients including psychiatric and psychosocial aspects
2. Develop a multidisciplinary team approach to the outpatient treatment of schizophrenic patients
3. Provide a system of mutual staff support and peer consultation
4. Provide a point of contact for the patients, their families and community agencies
5. Promote research, education and program development in the area of schizophrenia

Appendix C

Summary Outline of Program (Ministry Application: January 1983)

It is proposed to establish an aftercare clinic for schizophrenic patients and their families that will comprise several components. A system of case management involving the assignment of a prime therapist, and the contribution of a multidisciplinary team will be put in place with a designated psychiatrist in charge. Members of the team will act both as direct service providers and as consultants in their particular area of expertise.

The clinic will perform a coordinating function in relation to existing programs that serve the schizophrenic patient, e.g.,
outpatient, day therapy and social/recreation programs.

The clinic will provide a point of contact for staff, patients, their families, and community agencies. Patient and family crisis situations will receive quick and thorough response with the aim of preventing relapse and/or admission to hospital.

The clinic program will offer patient and family education about the medical and psychosocial aspects of schizophrenia in the form of teaching and support groups.

Finally, the program, through focusing on one particular patient population, will develop an intimate knowledge of gaps in service for the schizophrenia patient and consequently will produce comprehensive recommendations for further program development.

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