Analysis of Change Within a Mental Health Organization: A Participatory Process

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ABSTRACT: *This article documents the process of change of a mental health organization, using a case study that illustrates a shift in philosophy and practice based on the concepts of empowerment and community integration. The case study includes the context and motivation for change, planning and implementation, and outcomes of the change process. Drawing on personal experience and extensive evaluation information, three critical shifts are discussed in terms of issues and learnings: changing service delivery toward more individualized support, broadening the "ownership" base through stakeholder involvement, and beginning to shift the power and control through consumer participation. Dilemmas and paradoxes are noted throughout the process.*

In recent years, mental health systems for people with severe and persistent psychiatric disabilities have been undergoing a great deal of change. Institutional-medical models guided the early mental health systems, while an emphasis on psychosocial rehabilitation in community settings has been influential in the last two decades (Anthony, 1979; 1990). In spite of improvements over the institutional-medical model, the limitations of programs based on the rehabilitation model have been increasingly identified (Carling, 1995; Nelson & Walsh-Bowers, 1994; Trainor, Pomeroy, and Pape, 1993). The limited amount of consumer participation and self-determination, the over-emphasis on "client" change to the neglect of social systems change, the lack of focus on informal support and community participation, and the devaluation of consumers and family members' experiential knowledge are some of the problems that have been noted (Nelson & Lord, 1996)

In this decade, an alternative philosophy and method of practice, which is based on the concepts of empowerment and community integration, has slowly emerged to address the limitations of rehabilitation approaches (Carling, 1995; Czukar, Bouchard, & Bennett, 1990; Nelson & Lord, 1996; Trainor et al., 1993). While many organizations have been in the process of implementing these new ideas, there has been very little research which describes and analyzes the process of change which organizations go through to move in this new direction.

The purpose of this article is to document the process of change of a mental health organization, using a case study that illustrates a shift in philosophy and practice. To outline the context for this study of change, we will present our conceptual framework, which includes a brief discussion of mental heath reform and organizational change. We shall also outline the methodology, including our role as researchers or members of the organization and how we participated as change agents throughout the process. We shall then present a case study of the organizational change which occurred over a three year period. This will be followed by an analysis of the critical themes and issues which were experienced by this organization, with highlights and implications for other social change work of this kind.

Background/Framework

To understand the social context related to change within mental health organizations, first we briefly reflect on two main areas which have served as the framework for our work.

Mental Health Reform

Mental health reform in North America has been influenced by several factors including deinstitutionalization, growth of the consumer/survivor and family movement, and increased recognition that people with severe and persistent mental health problems can benefit from participation in community life (Carling, 1995). We concur with those who argue that consumer/survivors have often been oppressed and marginalized (Church, 1996; Lord and Dufort, 1996). Others point out that it is not simply mental health problems which beget oppression, but rather the nature of systems, both understood and invisible, that unnerve people's

confidence and competence (Burstow & Weitz, 1988; Carniol, 1996; Smith, 1990; Varcoe, 1996; Whyte, 1996).

Resource mobilization theory (Jenkins, 1983) provides a useful framework to understand social change in the mental health field. Resource mobilization theory says that the definition of a social problem is a claims making activity. Consistent with oppression and resource mobilization theory, psychiatric consumer/survivors have experienced degrading social conditions for centuries, but these conditions have only been recognized as problematic at certain periods of time. Exposé of inhuman conditions by claims makers has led, temporarily, to reform efforts. In this era, we are witnessing change in part because of a strong social movement of psychiatric consumer/survivors, families, and a broad network of professionals who are committed to reform (Nelson, 1994).

Change is central to the era in which we live. While people in general may consider change as a threat, social change theorists define change as something normal in the very nature of things (Lincoln, 1985; Zimmerman, 1996), which occurs in various directions, rates, and levels (Lauer, 1991). It is often noted that people tend to resist change, but others emphasize that innovation and breaking free of the conventional way of thinking is needed within organizations (Covey, 1990; Etzioni, 1991; Gardner, 1992; Senge, 1990).

The initiators of the change described in this article began with the assumption that they might be changing values and power relations. This "second order change" refers to "change in the assumptions, values, structural relations, and rules governing the system" (Bennett, 1987, p. 13). In mental health reform, values have often been described as key components which differentiate emerging mental health paradigms from traditional perspectives. Nelson and Walsh-Bowers (1994) identify three key values which distinguish traditional and emerging approaches: 1) stakeholder participation and empowerment, 2) community support and integration, and 3) access to valued resources. Carling (1995) outlines three roles which are consistent with the shift in mental health programs to an empowerment focus; 1) adoption of a community integration approach in all mission and policy statements, articulating values of self-

determination;   2) a change in the way professionals and agencies relate to people with disabilities in decisions about planning, funding, evaluating services and in hiring and training staff; and 3) transformation of services and systems so they are accountable to the people they serve by asking consumers and routinely evaluating all services in terms of concrete outcomes and consumer satisfaction.

One other shift in current mental health reform that has received some attention is the values and practices related to reducing power imbalance between service providers and consumers (Church, 1995; Trainor, Pomeroy, & Pape, 1993; Whyte, 1996). Trainor et al (1993) argue that the dominance of medical and social science knowledge is changing, giving more credibility and support to consumer/survivor and family experience and knowledge. While consumer/survivor participation and decision-making at all levels is an important reflection of this trend, some writers have pointed out the "unsettling" impacts of consumer participation for many of those who have power (Church, 1995; Lord & Dufort, 1996; Whyte, 1996). The unsettling dimensions include staff discomfort, hesitancy to share power, rejection of consumer anger, and confusion about the role and function of consumer representatives. The centrality of consumer participation was seen as fundamental by the organization that was involved in this process of change.

Organizational Change

In traditional organization change theory, organizations seek equilibrium (Zimmerman, 1996). In this kind of change, leaders generally "make it happen" and the change itself is generally from the "top down" (Etzioni, 1991; Zimmerman, 1996). In recent years, the organizational change literature has reflected a dramatic shift in thinking about how organizations can and should change for the benefit of the people they support (Bergquist, 1993; Handy, 1995; Kluger & Bager, 1994; Lincoln, 1985). Organizational theory and research now recognizes that it is not possible to anticipate the consequences of all organizational actions. Leaders are no longer seen as being able to control the structures and functions in their organizations. Increasingly, the focus of leaders is to facilitate the involvement of people

throughout the organization, to share information, and to provide opportunities to learn (Block, 1993; Senge, 1990; Weatley, 1992). Several studies report that workers' participation and involvement in decision-making and implementation of change are positively related to their perception of equity within the organization (Folger & Konosky, 1989; Bullock, 1983). More and more, changes in human service organizations are framed around participative decision-making processes that encourage planning and strategic changes from the "bottom up" (Carling, 1995; Handy, 1995; Lincoln, 1986).

There are also a number of factors identified in the literature related to why people and organizations resist change, including actual and perceived powerlessness, lack of information, and limited participation in the change itself (Handy, 1995; Sarri & Sarri, 1992; In a current study of the process of change in mental health organizations, both conflict and resistance were identified as changes began to be implemented (Nelson, Lord, Ochocka, 1996). "Changes posed a challenge to the identities of staff, who, to varying degrees, were threatened and felt criticized. The shift in roles that was required of staff also caused some strain for staff, as different attitudes and skills were needed to work within the new philosophy" (Nelson et al., 1996, p.4).

Some argue that the key to organizational change in this era is to effectively distribute power and purpose throughout the organization (Block, 1993). Consistent with this notion is the concept of developing the "learning organization", which is characterized by openness, team learning, shared vision, and high degrees of participation (Senge, 1990). The characteristics of organizational change that cut across many of these perspectives relate to systems thinking. This involves participants and organizations no longer seeing change as linear, but seeing change as an interacting process in a series of interrelationships. Shared vision and common purpose become central ingredients in organization change (Bergquist, 1993; Block, 1993; Kluger & Baker, 1994; Senge, 1990).

In mental health service delivery, it has been common to rely on staff to make decisions and determine directions. A stakeholder approach to service delivery means that people who have a stake in the organization are involved in any process for change. Partnerships are central

to organizational change that envisions a learning organization and high degrees of participation from stakeholders (Block, 1993; Lord, 1994; MacGillivary, 1996). In a recent case study on changes in the provision of housing support, Pyke and Lowe (1996) describe the involvement of staff and residents in planning and implementing a more individualized approach to support. As this study showed, each stakeholder group has something to contribute and something to benefit from being involved. Partnerships and collaboration among stakeholders was the chosen strategy for change in the organization described in this article.

Planning has often been assumed to be of value for organizational change. In the last two decades, strategic planning has been the dominant planning approach (Hax, 1987; Mintzberg, 1994). Strategic planning can be thought of as a formalized procedure designed to produce an integrated system of decisions (Bryson, 1988; Mintzberg, 1994). Strategic planning has also been criticized because formal planning often does not produce the expected change and because such planning is in fact seldom strategic (Mintzberg, 1994). Transactive planning has often been utilized to recognize the importance of experiential knowledge and the value of stakeholder involvement in planning for change (Friedmann, 1973). Dialogue and small group interaction are critical in transactive planning, which emphasizes the importance of social learning as the basis for planning and change. Although we called it strategic planning, the actual planning that occurred throughout this planning for change process included elements of transactive planning. Stakeholder participation and group learning were central elements of all decision-making.

Methodology

There were many sources of information for this article. During the entire process for change, several documents were produced, and these have formed the basis of much of our work. In addition, our roles as authors and significant players in the change process were an important source of insight. Before looking at the concrete steps of our methodology, we shall first locate ourselves in relation to the change process. This will situate the methodology in a personal and social context.

One of us, Wendy, has been the Executive Director of the organization since its inception and was responsible for initiating the change in collaboration with her board. John, was the facilitator of the planning sessions with stakeholders, and has worked closely with the organization as a consultant for the last few years. Joanna, was the coordinator of the evaluation, and worked with an evaluation committee within the organization to understand and assess the learnings and impact of the strategic planning process. Heather was the evaluation researcher hired by the organization to assist with the process and outcome evaluation of the strategic plan. Working closely with the evaluation committee and the evaluation co-ordinator, she produced several evaluation documents, including her own master's thesis related to partnerships within the organization change process (MacIllivary, 1996).

Each of us has brought a different perspective to the change process. These multiple perspectives have enriched our understanding of the complexity of the process. Although a consumer was not part of the writing team, the consumer voice was a significant part of all documentation of the change process. Our commitment to consumer participation has hopefully enabled us to capture the essence of this perspective in this document.

We followed three major steps in the process of writing this document:

1. We organized all documents produced during the change process. The documents included the strategic plan, an outline of the implementation strategy, the evaluation of the process of change, consumer and staff survey results, and a summary of consumer and staff focus groups. All of this information had been collected over a two year period during the process of change.

2. We reviewed these documents and our own experience during a series of writing team meetings. We used the documents as a platform for reflecting on personal and social themes and lessons. This in-depth dialogue included exploring social relations of ourselves and the change process and we noted contradictions, points of consensus, and points of divergence. These insights were recorded during a series of six collaborative meetings. By the end of this

period we had structured our writing around a conceptual framework, a case study of change, and lessons learned.

3. After completing a draft of the document, we shared it with seven stakeholders (three staff, three consumers, one board member, and one university researcher who had extensive knowledge of the organization and mental health issues). Each of these extensive reviews was then utilized to re-write the final paper.

Each of these steps is consistent with contemporary social research approaches (Denzin & Lincoln, 1994).

Case Study

Context

The Waterloo Regional Homes for Mental Health Inc. (WRHMH) is a non-profit, community based mental health housing and support organization which is located in Waterloo Region (Central-west Ontario). Waterloo Region consists of three cities, smaller towns, and rural areas, with the population of approximately 400,000. The region has three hospitals, one with a number of psychiatric beds and several hospital sponsored clinical community mental health programs, and two major community mental health service organizations: a branch of the Canadian Mental Health Association providing community support and WRHMH providing housing and support. There are also three self-help consumer/survivor organizations (Waterloo Region Self Help, Cambridge Active Self Help, and Depressive/Manic Depressive Association). Waterloo region has a broad network of other service organizations, self-help groups and community associations, which provide a variety of community and family support services.

WRHMH was developed in 1979 by a group of professionals, family members and concerned citizens in response to the lack of suitable, stable, affordable housing and support for people with serious mental health problems. While initially sponsored by the Canadian Mental Health Association, WRHMH established itself as a separate organization once funding was secure. Throughout the 1980s, the organization developed several housing options, including

group homes, bungalows, and apartments, totaling nine separate properties. In addition, three community support programs - Housing Registry, Boarding Home Support Program and Community Support Program with the local housing authorities - have been supporting approximately 150 people.

Purpose and Motivation for Change

In early 1991, the need for a formal strategic planning process was recognized by the board and the executive director. There were two major catalysts for the process of change: a) tremendous expansion of the organization, and b) influences in the field of community mental health. The organization had grown very rapidly in terms of programs, staff, and budget during a seven year period (1984-1991). Larger numbers of people served, expanded services, and increased numbers of staff all needed to be looked at in more systematic and comprehensive manner. Also, the role of the agency within a larger community context and increased interest in consumer participation required definition and review.

Broader trends in community mental health, changes in government direction, and a desire for service delivery improvement also stimulated the move towards planned change. The philosophy of empowerment and community integration began to touch the agency in 1991. The organization came in contact with new ideas from various resource people and settings, including a leader in mental health reform from Vermont, a professor from a local university doing research with the organization, the Ontario Federation of Community Mental Health and Addiction Programs, as well as policy from an interministerial committee. The Ontario government document Putting People First acknowledged the need to re-allocate resources from institutions to the community and reflected components of the new paradigm of community integration and empowerment (Nelson, Lord, & Ochocka, 1996). These influences contributed toward a shift in thinking within the staff and board.

Process of Change

Partnership and collaboration among stakeholders as well as group learning were considered key to the process of planning and change at WRHMH. In 1991, the process began

with leadership from the top of the organization. The Executive Director (Wendy), together with the board of directors stimulated and sanctioned the change process. The stakeholder Long Range Planning Committee acted as the driving force behind the planning and guided the overall strategic planning process.   This committee, on behalf of the board, involved an equal representation of consumers, management, front-line staff and board.   The review also incorporated an educational approach utilizing values-based training for agency stakeholders, a commitment to maximize stakeholders' participation in all steps of the process, and an external facilitator (John) to assist with planning sessions.

Generally, the process of change included six objectives: a) to clarify the agency's mission, and goals, comparing these with the philosophies implied/expressed in the literature, b) to compare the organization's new philosophy with the way services were provided, identifying areas that require changing, c) to compare the organization's new philosophy with the ways the organization was structured, including board and staff responsibilities, identifying areas that require changing, d) to establish long-term and short-term objectives that would ensure that the organization meets its new mission, e) to develop action plans that provide direction for the achievement of long-term and short-term objectives, and f) to develop an evaluation strategy for the process and on-going activity. Thus, the planning exercise placed a strong emphasis on the use of a values-based approach to change and the development of a shared vision and philosophy for the organization. Upon board approval of the above objectives, the external facilitator was hired to facilitate the strategic planning process.

The external facilitator played an important role in the entire process. It was critical that the organization hire a person whose values were similar to the agency's philosophy, who was able to lead groups in a participatory manner and who made this process effective and productive. As one person said: "Having an external facilitator was very good because he was able to give some sort of structure so we did not jump around and we had a neutral person to work with different groups."

Over the next 18 months (January 1993 - June 1994) stakeholders were brought together to work through each of the six objectives. People were exposed to different ideas, including listening to a number of speakers address community mental health or housing issues. Half-day or full-day workshops were held for each of the objectives. During these workshops, small groups (balanced for stakeholder representation) were formed to dialogue, make decisions, and present their views to the large group. Action teams were then developed to provide specific implementation activities and directions. It was an exciting time of extensive participation of consumers, staff, board and other community agencies representatives.   The stakeholders worked together on elements of a desirable future, assessment of services, suggestions as how to better provide services, examination of the agency's structure of responsibilities and communication patterns, development of short and long-term objectives and action plans. The plenary sessions were found to be vitally important to collectively discuss results and concerns and identify emerging themes. In between steps, the Long Range Planning Committee distilled group decisions and concerns, and incorporated them into the agenda for the next planning phase. This whole process was integrative and democratic with a strong emphasis on stakeholder participation and extensive consumer involvement.

Various people took leadership roles during the planning and implementation process, including members from the Long Range Planning Committee, the program director, several board members, and the external facilitator. The value of consumer involvement was widely recognized. This represented the first time that consumer/survivors played a major role in planning within the organization. The constant emphasis on stakeholder involvement ensured that consumers were well represented and consumers had an opportunity to become leaders in the change process.

The Implementation of the Strategic Plan Results

The final plan that was developed by the stakeholder process identified several strategies for changing the current service delivery system according to the mission and goals of the organization. These included: a) separating (de linking) housing from support, b) providing

flexible, portable support services based on individual needs and choices, c) enhancing crisis services (intervention and prevention), d) revising eligibility criteria, and e) assisting individuals with securing a wide range of housing options.

Implementation of the extensive changes outlined in the strategic plan needed strong directions and action-oriented people. The Implementation Committee was established in November, 1994. The committee recognized the need to work closely with a newly formed Evaluation Committee. In this way, the changes outlined in the strategic plan were to be shaped by feedback from evaluation findings in order to ensure that they were connected with implementation decisions.

The membership of the implementation and evaluation committees consisted of representation from stakeholders including consumers, staff, community agencies' representatives, management, and an external consultant. To be effective, the implementation committee decided to start by focusing on the support service component of the strategic plan. Each goal developed in the strategic planning process was reviewed by the committee and action plans for implementation were developed by all members. As one person said:

> The development of the implementation and evaluation groups, with all stakeholders, helped a lot because people had some say in driving the implementation and had some accountability.

Outcomes

The strategic planning and implementation process led to several changes in the service delivery system at WRHMH. The process clarified the agency's values and directions and what services were to be delivered. The organization became strongly committed to making support more individualized, flexible, and portable and to delinking housing and support.

The evaluation results showed that many positive results reflected the changes at different levels of analysis. At the level of individuals who are supported by the organization, consumers now feel they have increased control over services, have felt more independence, and have experienced enhanced community integration. These findings are consistent with McCarthy and Nelson (1993), who also found that residents increased their independence after entering

supportive housing projects.   Consumer/survivor participation in the organization has also increased. Consumers expressed their satisfaction with the whole process of strategic planning and implementation of changes; people felt they are better informed and more included.

At an organizational level, positive outcomes included increased participation and feelings of "connectedness" among stakeholders. Resources were now dispersed among a larger number of consumers, as reflected by crisis supports and practical life skills now being available to all consumers, not just those in the groups homes. All stakeholders expressed that they are informed and certain about future directions of the organization.   Furthermore, WRHMH's positive image among other community organizations increased.

Themes and Issues

Three themes and issues emerge from our analysis of this case study of change in a mental health organization. Each will briefly be discussed, and we shall note possible learnings for mental health change.

Service Delivery: Shift Towards Individualized Support

The service delivery that resulted from the change process emphasized a shift in providing services from a program approach to an individual approach.   This change was accomplished by delinking housing from support and developing a flexible, portable support service responsive to changing individual needs and based on consumer preferences. The delinking involved separating access to and availability of housing services from support services.   This meant that accessing housing was no longer contingent on accepting a predetermined level and kind of support and visa versa.

This shift in emphasis ensured that people would be supported regardless of where they lived in the community. People no longer had to move from one home to the next, graduating from each and eventually moving to an independent living situation once they had acquired an expected skill level for such living. Even though supportive counselling was available to all people supported by the organization, practical support was previously only available to people living in group homes and 24 hour crisis support was previously only available to people in

agency-owned properties. The shift towards individualized support meant that practical and 24 hour crisis support, two critical supports in helping people to live independently in the community, were now available to people living outside of the group homes and agency owned properties. Hence, individuals had more control in choosing the type of housing and support that they needed based on their own instrumental, social and lifestyle needs. People could choose whether they wanted group or independent living. They had control over the decisions related to the level and intensity of supports. Individuals living in group homes who no longer needed the level of support provided to people in the home did not have to move if they did not want to. People who wanted to remain for other reasons such as subsidized rent, shared responsibilities, home location and proximity to other services and friendships could do so. People who wanted to leave group homes to live more independently did not have to change support workers. Their supports followed them wherever they chose to live in the community.

In addition, people living independently who were experiencing a stressful period and having difficulty coping with day to day responsibilities, could access more support to help them through the difficult period. This increased support has decreased the need for hospitalization and prevented housing loss.

<u>Learnings</u>**.**   This shift toward individualized, flexible supports is in keeping with the emerging mental health paradigm described by Carling (1995) and Nelson and Walsh-Bowers (1994). These authors emphasize the importance of comprehensive support which is *flexible* and *responsive* to the consumer. In our evaluation of these changes, we found that the shift in service delivery towards individualized support was well received by consumers, especially for those moving to more independent living arrangements of living by themselves. A number of persons commented that the service was better and more responsive. One consumer noted, "I have more control and moving isn't so scary knowing my support worker goes with me."

Consumers also liked the increased flexibility of the support services, especially those that lived in more independent living arrangements within the community. One consumer emphasized;

> Support is heavier (daily or weekly) if I need it or lighter (every few weeks) when it not so necessary. It gives me a comfortable feeling to know that I can get the amount of support that I need.

People living outside of the agency owned properties also liked the increase in availability of practical support and 24 hour crisis support. Staff commented that the changes, while at times difficult for them due to the unpredictable nature of the demand, are better for the consumer. Knowing that supports were flexible was especially reassuring for consumers who were worried about becoming ill again and losing everything they have. The evaluation showed that some group home residents, especially if they had a good relationship with their support worker, were not as pleased with the changes if they perceived the change as a loss. Other group home residents were quite satisfied. The evaluation also showed that people supported by the organization liked having their worker stay with them wherever they lived.

We also found, despite our best intentions to delink housing and support, that there are challenges in doing so. This was particularly true in the case of our 24 hour high support home. Support is such an intricate part of helping people choose, get and keep their housing. Although we were successful in officially moving staff offices from the low to medium support homes to the agency's head office, this was not possible to do for the 24 hour support home. Additional dollars were not available to acquire office space to house the 1-2 group home staff plus the Co-ordinator in the main office. More importantly, and based on consumer preference, staff needed to be readily available to consumers living in the homes, especially the more high need, vulnerable residents. We had difficulty rationalizing locating the staff elsewhere when they were often called upon during the day and evening to assist with life skills and at night for consumers who wandered about. Although we continue to believe that housing and support need to be delinked in order to maximize the flexibility of resources, we are learning that in some situations, these functions continue to be intricately related. The main lesson for us is that there is no one single right way of supporting people in the community.

Stakeholder Involvement: Broadening the "Ownership" Base

Involvement of stakeholders at WRHMH was initially entrenched in the structures of the strategic planning process. In the early stages, the Long Range Planning Committee which oversaw the strategic planning process was expanded to ensure balanced stakeholder representation for all planning work. This committee served as a model for stakeholder group decision-making and set the tone for later organizational committee structures and processes. We knew that the success of this committee's work was critical to the change process. A number of elements were incorporated into the committee's structure and processes. The facilitator hired to assist with the strategic planning process, took on a leadership role in facilitating the group to carry out the strategic planning process objectives. A democratic process for decision-making was incorporated and the group established principles to guide their own governance.

At all levels of the process, each stakeholder group was given equal say. This was a shift in emphasis for the organization, as previously decisions were made by board and management and influenced greatly by family members. Front-line staff and consumers were now equal partners at the table. To ensure that this shift happened, meetings were carefully planned and conducted so that all participants had an opportunity to share their views. Consumers were encouraged to speak up. Their views were given careful consideration. The facilitator's previous relationships with many of the stakeholders helped in establishing trust for the process. The facilitator also regularly debriefed with members after meetings to ensure that needs were met and issues were dealt with. This climate of mutual respect and equal consideration facilitated the development of partnerships. It also laid the foundation for the stakeholder involvement that would continue throughout the strategic planning and process. These processes were consistent with the increased attention being given to participatory decision-making in human service organizations (Block, 1993: Bullock, 1983; Lincoln, 1986).

We also utilized a values-based training approach for agency stakeholders. People were brought together periodically to learn about changes in the mental health field, given an opportunity to digest information and later share their thoughts about what changes should

happen in the organization. Task groups, again with balanced stakeholder representation, were established to develop action plans. This entire process created incredible momentum marked by increased interest in the development and outcome of the plan. Although this process involved some degree of conflict, especially between consumers and family members, this tension was minor in comparison to the enthusiasm and ownership that was generated for the plan by all stakeholders. Meetings were well attended. Staff, consumers, family, board and community representatives worked collaboratively throughout the process. Our results were consistent with Guba and Lincoln (1989) who argue that a balanced stakeholder approach requires a carefully crafted process involving negotiation and skilled facilitation.

Many consumers eagerly awaited implementation for which collaboration was more difficult to achieve. The implementation did not carry with it the momentum that the strategic plan did. The organization did not have the financial resources to continue the involvement of the external facilitator on a long-term basis. It was also difficult and overwhelming to use existing resources to carry out continuous, all inclusive process for implementation of all of the details.

Hence, existing staff structures were used to carve out the details of the service changes and roles for staff. For a period of time, senior staff and the management group assumed this role. Consumers left out of this part of the process were concerned about the slow pace of the implementation as well as staff who were more ready for implementation. These concerns, along with management's discomfort about the lack of balanced stakeholder representation in the implementation planning, led to the development of an Implementation Committee, again ensuring such representation. This committee reviewed the work of the senior staff and worked on other recommendations of the strategic plan. The work of the senior staff and implementation committees was later shared with the organization's consumers, staff, board members and community representatives at an agency community forum.

Issues which emerged during implementation became even more evident during the evaluation. Senior staff who were affected by the changes became more critical of the process.

They experienced the changes, but were not instrumentally involved in the actual implementation planning other than one representative and their own attendance at the forum.

Learnings. Overall the strategic planning process was a valuable and worthwhile process. The organization's "readiness" for such a process contributed to its success. Basic elements were in place such as trusting relationships and a genuine desire to improve services. The inclusiveness of the process involving family, consumers, board, staff and the community as equal decision-making partners at the table solidified the commitment to the process and to the plan that was created. We learned the importance of relationships in the process of change. Etzioni (1991), Senge (1993), and Zimmerman (1996) all emphasize the power of sharing information and the importance of relationships in the process of change.

However, despite the inclusive nature of the strategic planning process, the evaluation showed that staff experiences were not homogeneous. All full-time, part-time and casual staff surveyed indicated they were familiar with the strategic plan. Although almost all full-time and part-time staff indicated that they were involved in the strategic planning process to some degree, the degree of involvement varied. Staff perspectives on the strategic planning process were also mixed. One staff expressed that the process was a token or preordained process. Another staff indicated:

> It is educational and encouraging to participate with an agency in the process of change, focusing on consumer needs. Although changes are difficult and confusing at times, they get easier with time. It has been a positive time for me in general, being part of the process, not on the outside looking in.

According to the evaluation, staff identified a key challenge to their participation in the strategic process. First, staff felt that at times they were playing dual roles that were in conflict. While an important stakeholder in the planning process, they also felt they had to support consumers, who were another important stakeholder in the planning process. As a result staff may not have contributed as fully as possible to the process and they may have indirectly influenced the contribution of consumer stakeholder to the process. As one staff person said,

We were there to give input but we were also busy supporting people (so) that we could not give input and participate as needed.

The "ownership" that was experienced and articulated with the creation of the strategic plan was not experienced during implementation. Ownership was more limited. Senior staff were particularly affected as their roles began to change with the delinking of housing and support. Co-ordinator staff no longer were solely responsible for the house and the people within it. Some senior staff members were described as experiencing a loss of ownership over programs, while others expressed they felt a loss of identity. These struggles of staff are typical of change, which is often seen as a threat to conventional ways of thinking and acting (Covey, 1990; Etzioni, 1991; Senge, 1990). In this case, the planning and implementation were designed to support staff to move out of their program boxes and toward ownership of the whole organization and individualized support. This "role change" and process of "redefining identity" was difficult for staff.

Implementation of the plan was the most difficult part of the change process. Although the plan provided direction in terms of action plans and target dates for starting and completing tasks, we did not provide for sufficient implementation planning time where specific details around implementation would be ironed out and initiated. As a result, some people felt that the changes were not occurring fast enough. Other staff such as the 24 hour support home staff expressed concerns that the changes were too rapid.

In repeating the process, we would add a step in the development of an implementation plan that would map out all of the changes in detail. We also recognize there may be a paradox related to this desire. As Mintzberg (1994) has emphasized, formal planning may not produce what is expected and may not be strategic. Thus, our desire to be more precise is mediated by the need to be open and strategic in an ongoing way.

Genuine Consumer Participation: Beginning to Shift Power and Control

Most consumer/survivors have been oppressed and marginalized. These experiences make it challenging to engage consumers in processes of change. People may simply not believe

that efforts to involve them are genuine. Yet, consumer participation was evident throughout the planning, implementation and evaluation processes. Consumers contributed as individuals in small and large group sessions, and as committee members. A significant number of consumers, at least 25% of the total participants, were involved throughout the process. Initially characterized only by presence, participation increased and strengthened throughout the process.

Waterloo Regional Homes' commitment to consumer participation, we believe, contributed significantly to its success. This commitment was evident from the beginning of the planning process. Management sent individual letters to every person supported by the organization, personally inviting them to participate in helping the organization plan its future. Follow-up contact was provided by staff, either face to face or telephone, encouraging people to attend the planning sessions. Door to door transportation and meals were offered and provided. As others have noted, nurturing consumer participation requires attention to emotional details and respect for diversity of learning styles (Scott, Pomeroy, & Pape, 1995).

As indicated earlier, consumer involvement during the strategic planning phases was characterized primarily by presence. However, even presence required substantial encouragement by support workers, and follow-through by the Program Director. Many of the consumers involved were individuals who historically were not able or confident enough to discuss their needs and the kinds of services that they would find helpful. This process was very new to many consumers who had never experienced sitting at a table with other consumers, family members, staff and management. Problems with anxiety were common.

Consumers also had difficulty concentrating for long periods of time. People often left the meeting rooms suddenly, sometimes settling unassisted, but more often than not, requiring support from staff and peers to return to the group or committee meeting. People needed reassurance that their presence was beneficial and that their opinions were valued. They also needed reassurance that sudden departures would not be frowned upon or viewed as abnormal.

Consumers initially said little as individuals within small and large group contexts or as committee members, but this status gradually changed. Over time and with the continued

encouragement of small and large group facilitators and committee chairpersons, consumers became increasingly vocal. Management encouraged staff to continue to support consumers; the support involved a number of activities, from transporting consumers to meetings to spending time debriefing with consumers after meetings.   When consumers were asked during the evaluation why they continued to be involved, several responded that the respectful way that they were treated was a major factor. They were encouraged to speak up. Their opinions were validated.   A consumer participant on the Implementation Committee indicated that he appreciated that his views were solicited, and his ideas were given careful consideration. Management and group facilitators acknowledged his ideas, noted them in the action plans and discussed them in the group to determine how to implement them. In other words, consumers were never treated as token. A number of other consumers expressed that the motivation to become more involved in the organization came from being asked about what they thought regarding service delivery changes and carefully considering those ideas.

This environment of mutual respect and problem solving served to fuel consumers' drive to become more involved, especially on the implementation and evaluation committees. Consumers on the evaluation committee also played a major role in designing user friendly evaluation tools, volunteering to speak to other consumers about the evaluation, assisting in compiling and processing the data that was used for the support service evaluation and making recommendations for changes to services and policies. Consumers were actively involved in every step of the evaluation process.

As the change process evolved, consumer leaders emerged. The emerging consumer leaders served as mentors for other consumers whose confidence in themselves and the organization grew over time.   This confidence has lead to our current situation whereby consumer representation on the Board of Directors is greater than 30%. It is also the only stakeholder group with sufficiently more nominations than there are vacant positions.

Learnings. Changes have occurred in the organization to ensure consumer involvement in individual and organizational service planning and evaluation of the services. Consumers now

have more say in the services that are provided on their behalf. New service principles that staff utilize emphasize self-determination, empowerment, participation and community integration. Consumers are also now instrumentally involved as leaders in the organization in policy development through their involvement on tenant groups, management advisory groups, and on the Board of Directors. Overall, we can say that the organizational culture has changed to be more accommodating of consumer strengths and preferences.   These changes respond to Carling's challenge that agencies should change the way they relate to people with disabilities and make services and systems accountable by asking consumers what they think (Carling, 1995). Others have noted the importance of reducing power imbalance by involving consumers in decision making at all levels (Church, 1995; Lord & Dufort, 1996; Nelson & Walsh-Bowers, 1994).

We have learned that shifting power and control to consumers is a challenge that is not resolved overnight. Three years since the beginning of this change process we continue to be supporting the shift and reinforcing new ways to enable this to happen. The challenge of shifting power is twofold. Many consumer/survivors have been so marginalized that they may lack motivation and even feel rather hopeless. As noted, it may take along time, and a lot of trust, for this to change. We have also noted incredible growth among several consumers, demonstrating that the shift can happen. However, what is required is for staff and organizational structures to change. This is the second challenge, because as we have seen, staff may be cautious to change. As one example, moving an organization toward a strengths based approach (Saleebey, 1992) means staff must overcome protective thinking and learn the true meaning of empowerment. Staff are beginning to have confidence in these principles and new community approaches. We are now in the process of developing staff teams, which will be another vehicle for staff to enhance their learning and commitment.

Conclusion

Our understanding and analysis of change within a mental health organization has identified important learnings related to genuine consumer participation, enhanced stakeholder

involvement, and the development of more individualized service delivery approaches. The evaluation which was part of our entire process provided insights of great value to the organization. Although we did not realize it when our change process began, these four areas are in many ways cornerstones for creating and sustaining an effective learning organization (Senge, 1990). We have certainly learned that change within the context of mental health reform is not simply a procedure to be carried out and finalized. The notion of the "learning organization" - the concept of learning together, captures the sense of collaboration, strategic thinking and constant reflection that needs to be part of ongoing change.

We learned that genuine consumer participation can happen and that many strategies are required for it to occur in a constructive manner. We have now come to understand that these strategies begin with our own compassion, reflected through listening and validating the lived experience of people with serious mental health problems. We believe that consumer participation was not only about providing input to our change process but about shared decision making, education and partnership. In practice, this has meant that the formal meetings that were part of the change process were only one of the avenues for consumer participation. As we have discussed, there needs to be plenty of pre-meeting and post-meeting activity related to support and relationship building. Finally, our case study is part of a growing body of knowledge that consumer participation consists of a set of values and approaches which are central to the new paradigm in community mental health (Church, 1996; Nelson & Lord, 1996). None of the other changes which we have noted matter very much without the person him or herself participating in the process at the individual level, small group or team level, and the organization and policy level.

We also found that stakeholder involvement is a critical strategy for change within a mental health organization. Our experience suggests that stakeholder involvement and empowerment need to become key values in mental health reform. It is not always readily apparent why effective stakeholder involvement works, but we have some important clues from our experience. First, stakeholder involvement contributes to a diversity and openness that

creates the possibility of new energy and ideas being generated. Principles that encompass voice and choice, open communication, power sharing and participation in planning sessions are important components of creating ownership and positive attitudes during implementation stages. Although in our strategic planning process, we had to work hard to find common ground, the effort itself produced richer suggestions and solutions than would have been the case if we had not had such diversity. Second, stakeholder participation works when safe places are created for dialogue that is carefully facilitated. In this manner, support can be provided that is both practical and challenging. This approach was found to be very effective in our context. We recognize that there might have been benefit to having separate stakeholder groups meet on their own from time to time (Pyke & Lowe, 1996). This would honour different communities (e.g. consumer/survivors, families, staff, etc.) to explore and clarify their own issues and have an opportunity for more venting as needed.

As we move more and more into the emerging paradigm, we recognize its complexity. It is particularly challenging to implement, when so many of the existing structures and experiences are embedded in more traditional ways of thinking. As we have discovered, utilizing a stakeholder approach requires more negotiation and problem-solving. We are finding that the increased voice for consumers has been very positive, but the required role change for staff continues to be challenging. We struggle with the added dilemma that there is an array of staff and consumer voices, not just two stakeholder perspectives. While it is not always clear how to resolve issues, we are learning that we need to be principle centred and appreciative of the need for ongoing change.

As our service delivery is becoming more individualized, we are beginning to find that consumer satisfaction and indicators of success have a great deal to do with consumer perceptions of getting the services they want when they need them. Although the individualized focus was important for consumers, we noted a shift in consumer participation and control. An increasing number of consumers started to play more active and leadership roles in their own service delivery. This finding has recently been confirmed in another study conducted by the

Ohio Department of Mental Health, which reported that more favorable outcomes were associated with consumers reporting having their needs met, with consumers' say in services, and with adequacy of contacts with the mental health system (Roth, 1996). Becoming more individualized has meant that the organization and staff have paid more attention to service principles to guide the way their work. Our experience is that there is power in principles as a way of clarifying and leading (Covey, 1991).

Our evaluation was an important part of the change process. Consumers, staff, families and other stakeholders provided insights about the process and their relationship with it. This work has expanded the culture of evaluation and the concept of learning together within our organization. We believe this happened in part because of the focus on qualitative methods and participatory action research. Both of these approaches are a "good fit" with community mental health change and more consistent with the new paradigm than traditional research approaches. We have also found the importance of thinking more about a diversity of outcomes and a need for new indicators, recognizing that the meaning of quality of life will vary from person to person.

Finally, as our change process continues, the metaphor of "team" is emerging as one way of understanding how we work together for change. Our own writing team reflected the values and principles that have started to emerge throughout the organization. Dialogue was central to the way we worked, as we listened and noted our commonalties and differences. Trust was a base for building relationships. Keeping the vision clear throughout all steps of planning and implementation while focusing on details, open communication and mutual respect facilitated a good process of collaboration.

Generally, the change process at Waterloo Regional Homes for Mental Health has reflected democratic participation and collaboration through the planning, implementation and evaluation. In some ways, our changes are just the beginning. We now face major restructuring as psychiatric hospitals across our province begin to close, as consumer voices express more clearly their dreams and goals, and as access to valued resources is still limited. Our first steps in

the journey of change have been helpful to us and we hope that they have been helpful to others as well.

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