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WESTERN UNIVERSITY

Overcoming Resistance when adopting a Strengths-based Case Management Service Delivery
Model

by

Sheri-Lynn Mayhew

AN ORGANIZATIONAL IMPROVEMENT PLAN

SUBMITTED TO THE SCHOOL OF GRADUATE AND POSTDOCTORAL STUDIES

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OVERCOMING RESISTANCE IN SERVICE DELIVERY

Abstract

In 2016, Rapp & Goscha's (2012) Strengths-based Case Management (SBCM) Service Delivery Model was adopted as an agency wide, best practice within Organization X. However, the clinicians within Service N, who support persons with developmental disabilities and mental illness, known as a dual diagnosis, resisted this service delivery model implementation.

Outcome measures following implementation for those with a dual diagnosis were poor.

Specifically, goal attainment and fidelity scores were consistently lower since Rapp & Goscha's (2012) SBCM Service Delivery Model implementation. This Organizational Improvement plan (OIP) examines which leadership theories and frameworks could address the resistance in

adopting Rapp & Goscha's (2012) SBCM Service Delivery Model. Using transformational leadership, Cawsey et al.'s (2016) Change Path Model and Kotter's (1996) Eight-stage Model, a proposed change plan was suggested which identifies two solutions. Solution one involves

family and caregiver participation in gathering pertinent information for the Strengths Assessment and Personal Recovery Plan when a client is unable to provide this information.

Solution two involves differentiated capacity building which augments tools to deliver service based on a client's multiple intelligences and learning styles. Both solutions will be

implemented in combination within the change implementation plan. This OIP outlines the need for change, monitoring and evaluation components of the change plan and future considerations.

Keywords: Strengths-based Case Management Service Delivery Model, dual diagnosis, transformational leadership, Change Path Model, Kotter's Eight-stage Model, differentiated capacity building

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Executive Summary

This Organizational Improvement Plan (OIP) concerns a non-profit organization within Ontario. Organization X has a commitment to deliver evidence based, intensive case management as a best practice to support persons with mental illness. Service N is a program within Organization X dedicated to supporting the needs of persons with developmental disabilities and mental health challenges, known as a dual diagnosis. In 2016, Organization X adopted Rapp & Goscha's (2012) Strengths-based Case Management (SBCM) Service Delivery Model, to improve intensive case management service delivery agency wide. This service delivery model specifies a set of principles, methods, and tools to deliver strengths-based, intensive case management. Rapp & Goscha's (2012) SBCM Service Delivery Model presumes individuals have a level of functional ability to participate in strengths-based, intensive case management. However, clients within Service N were incurring lower scores on fidelity measures and lower goal attainment outcomes under this service delivery model. Consequently, the clinicians within Service N displayed resistance in adopting this service delivery model with clients with a dual diagnosis. Thus, the Problem of Practice (POP) queries what leadership theories and frameworks could address the resistance within Service N in adopting Rapp & Goscha's (2012) Strengths-based Case Management (SBCM) Service Delivery Model.

Chapter One introduces Organization X, outlining the organizational structure and leadership composition. Three case management service delivery models are discussed and differentiated. A discussion of the deinstitutionalization of persons with developmental disabilities into community settings highlights why effective case management supports are required within the developmental sector (Durbin, Sirotich, Lunskey, & Durbin, 2017). Since 2016, quantitative data reveals fewer clients are being supported by Rapp & Goscha's (2012) SBCM Service Delivery Model. Tacit knowledge, client testimonials, goal attainment scores

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along with client and clinician satisfaction survey results suggests challenges using the service delivery model. These challenges appear to have contributed to the affective, behavioral and cognitive resistance by the clinicians within Service N towards using Rapp & Goscha's (2012) SBCM Service Delivery Model (Aarons & Sawitzky, 2016; Erwin & Garman, 2010; Kebapci & Erkal, 2009).

A gap between the current and future organizational state further highlights the importance of this OIP. Canadian statistics show an increase of individuals reporting developmental disabilities and mental illness highlighting the increasing need for effective community supports (Statistics Canada, 2018). Bolman & Deal's (2013) Four Frame Model assists the conceptualization of organizational resistance within Organization X. Macro, meso and micro level factors influencing the POP, are explored. Numerous change drivers are identified. The Program Manager's leadership style and capabilities are discussed in relation to this OIP. An assessment of the organization's change readiness state is suggested, prior to the reintroduction of Rapp & Goscha's (2012) SBCM Service Delivery Model within Service N.

Within Chapter Two, transformational leadership, Cawsey, Deszca, & Ingols' (2016) Change Path Model and Kotter's (1996) Eight-stage Model are identified as necessary for leading the change process. A critical organizational gap analysis is conducted using Nadler & Tuschman's (1980) Congruence Model. Four solutions to the POP are presented and assessed. The recommended solution combines two possibilities; involvement of family and caregivers in service delivery and differentiated capacity building. Ethical considerations are framed, highlighting social worker professional practice and conduct within Service N.

Chapter Three outlines a detailed change implementation plan for Organization X, utilizing Cawsey et al.'s (2016) Change Path Model as the strategy for managing the proposed

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change. Short, medium, and long-term goals are identified, which further align with Cawsey et al.'s (2016) Change Path Model and Kotter's (1996) Eight-stage Model. Advantages and limitations of each goal are identified and discussed. It is necessary to monitor and evaluate the change process by employing two consecutive Plan-Do-Study-Act (PDSA) cycles for each recommended solution. Klein's (1994) eight key principles are utilized within the organization communication strategy. A communication plan identifying short, medium, and long-term goals is outlined. Next steps and future considerations are acknowledged and discussed. Successful implementation of this OIP has the potential to improve goal attainment for persons with a dual diagnosis while also improving strengths-based, intensive, case management service delivery.

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Glossary of Terms

Developmental Disability:	Used interchangeably with intellectual disability to refer to an individual with an IQ of less than 70
Differentiated capacity building:	The development of resources, effective practices and tools tailored to the learning needs and capabilities of the clients within Service N
Dual diagnosis:	A person with a mental illness and developmental disability
I-START Program:	Iowa Systemic, Therapeutic, Assessment, Resources & Treatment; an evidenced-informed, community, crisis prevention and intervention model for use with persons with intellectual disability and mental illness
Intellectual Disability:	Used interchangeably with developmental disability to refer to an individual with an IQ of less than 70
OIP:	Organizational Improvement Plan
Organization X:	Pseudonym for the Organization within the OIP
PDSA cycle:	Plan-Do-Study-Act cycle
PESTE:	Political, economic, social, technological and environmental analysis
POP:	Problem of Practice
SBCM:	Strengths-based Case Management

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Service N: Organization X's program that attends to the case management needs of persons with mental illness and developmental disability

CHAPTER ONE

INTRODUCTION AND PROBLEM

The purpose of this Organizational Improvement Plan (OIP) is to explore the following Problem of Practice (POP): what leadership theories and frameworks could address the resistance within Service N in adopting Rapp & Goscha's (2012) Strengths-based Case Management (SBCM) Service Delivery Model? This chapter introduces the organization, exploring social and historical context. The aspirations of the organization are explored through the agency's vision, mission, values and goals. The relationship between the organizational structure and established leadership approaches is examined. The leadership position and POP are articulated. Furthermore, the POP will be examined, considering theory, literature, research and professional experience.

Organizational Context

The Organization, hereafter respectfully referred to as Organization X, is a non-profit agency, with a mission to provide case management supports to clients with mental illness within a large, urban city in Ontario (Organization X, 2018a). Organization X has a functional organizational structure with a vertical hierarchy whereby the organization's programs are further divided by functional specialities (Galbraith, 2014). For example, within Organization X, there are unique programs dedicated to supporting individuals involved in the criminal justice system or those experiencing homelessness. Service N is a program-specific service which supports the mental health needs of persons with an intellectual or developmental disability, known as a dual diagnosis. Within Canada, the terms developmental disability and intellectual disability are used synonymously and these terms will be used interchangeably throughout this OIP. A person with a developmental disability has, since childhood, identifiable deficits in

adaptive functioning and intellectual potential, unable to meet the standards expected for his or her age group or culture (Griffiths, Stavrakaki, & Summers, 2002). The Program Manger of Service N supports a small team of specialized clinicians who provide intensive case management services to clients with a dual diagnosis.

History of the organization. Case management services emerged in the 1960s as an intervention to help support persons with mental illness within the community (Hangan, 2006). Case management was and continues to be identified as one of the most effective practices to support vulnerable populations, including those with mental illness or those with developmental disabilities (Gaboda, 1999; Gabriel, 2004; Griffiths, Stavrakaki, & Summers, 2002; Rapp & Goscha, 2012). However, only a very small portion of social work practice literature addresses case management research involving persons with developmental disabilities (Gaboda, 1999; Gabriel, 2004). In fact, a comprehensive literature review in preparation for this OIP yielded no research involving Rapp & Gosha's (2012) SBCM Service Delivery Model and persons with a dual diagnosis.

There exist three different case management service delivery models; broker, intensive case management and strengths-based case management (Loveland, 2002). Each of these models share common features which include supporting vulnerable individuals, performing assessment and planning, monitoring, advocacy and utilizing resources to deliver service (Campbell & Globerman, 2014; Gaboda, 1999; Gehrs et al., 2004; Macias, Farley, Jackson, & Kinney, 1997; Vanderplasschen, Wolf, Rapp, & Broekaert, 2007). It is challenging to identify unique characteristics among these case management models due to these common characteristics; nonetheless, distinctions are evident. The broker model is a significantly brief approach to case management, consisting of a maximum of two contacts with a client to

complete a needs assessment prior to the community resource referral (Vanderplasschen, Wolf, Rapp, & Broekaert, 2007). This type of case management is considered the least intensive service (Gaboda, 1999; Vanderplasschen, Wolf, Rapp, & Broekaert, 2007). On the other hand, intensive case management requires outreach support by case managers, and crisis intervention with an increased intensity of contact and supports. Caseload size is smaller and a team approach is frequently utilized (Vanderplasschen, Wolf, Rapp & Broekaert, 2007). Conversely, strengths-based case management stresses the client-case manager relationship, while focusing on a client's strengths, goals, and use of naturally occurring resources within community networks (Rapp & Goscha, 2012; Siegal, 1995b). Furthermore, strengths-based case management is considered the most intensive form of case management having the most frequent contacts and direct care with clients and community resources (Rapp & Goscha, 2012; Vanderplasschen, Wolf, Rapp, & Broekaert, 2007).

Historically, Service N has delivered a broker model of case management while all other programs within Organization X delivered intensive case management supports. In 2016, with the introduction of a new strategic plan, Organization X adopted Rapp & Goscha's (2012) SBCM Service Delivery Model agency wide. The aim was to enhance case management service delivery, efficiency of program supports, and as a support to help decrease emergency room utilization and hospitalization (Organization X, 2016). Thus, since 2016, Service N has engaged in an organizational change process moving from the broker model of case management to Rapp & Goscha's (2012) SBCM Service Delivery Model while all other programs migrated from intensive case management to strengths-based case management service delivery. Evolving all programs within the organization towards strengths-based case management highlighted the

significant commitment from the organization in delivering client-centered care, impacting staffing, training, resources and clients (Hangan, 2006).

Vision, mission, purpose, and goals. With a commitment to collaborative consumer and stakeholder partnerships, the mission of Organization X addresses social responsibility by supporting clients with mental illness (Organization X, 2017). The values of the organization include continuous improvement, equality, and leadership. With the implementation of a new strategic plan in 2016, Organization X sought to evolve case management support to improve community-based mental health services in compliance with provincial case management service standards (Ontario Government, 2005). Thus, the organization adopted Rapp & Goscha's (2012) SBCM Service Delivery Model.

Over the last 30 years, Rapp & Goscha's (2012) SBCM Service Delivery Model has undergone refinement, to include a set of values, principles, theory, practice and fidelity expectations for the delivery of strengths-based, intensive case management supports for persons with mental illness (Rapp & Goscha, 2012). The goal of this service delivery model is to assist people in life transformation by identifying and securing a range of environmental and interpersonal resources to achieve personal goals and promote recovery from mental illness (Burns & Rapp, 2001; Rapp, 2014). The model is based on the following six principles: persons with mental illness can recover, all individuals have strengths and can determine recovery goals, clients direct their service, community resources should be optimized, and the client-case manager relationship is paramount (Burns & Rapp, 2001; Rapp 2014; Rapp & Goscha, 2012). These six principles align well with Organization X's mission and values. Rapp & Goscha's (2012) SBCM Service Delivery Model is different from other case management models due to the structure and required practice components, low number of clients per case load, structured

weekly supervision, the required use of the Strengths Assessment and Personal Recovery Plan, and collaborative partnerships with community resources (Burns & Rapp, 2001; Rapp 2014; Rapp & Goscha, 2012). However, there lacks a clear and definitive description of the strengths-based approach due to commonly shared case management characteristics (Campbell & Globerman, 2014; Ibrahim, Michail, & Callaghan, 2014; Vanderplasschen, Wolf, Rapp, & Broekaert, 2007). Despite this challenge, it is evident that strengths-based case management is a clear departure from the broker model of case management.

As a non-profit organization, Organization X relies heavily on the province for operational funding. To increase the likelihood of continuous annual funding, Organization X must demonstrate that case management support services help to reduce the overall cost to the Ministry of Health and Long-Term Care (MOHLTC) through statistics reflective of decreased emergency room and hospital utilization. In a critical review, research found the strengths-based case management approach does decrease length of hospitalizations in persons with psychiatric illness (Bigelow & Young 1991; Macias, Kenney, Farley, Jackson, & Vos, 1994; Tse et al., 2016). Furthermore, research found that the strengths-based case management model produced statistically significant results indicating the reduction of psychiatric hospitalizations, the reduction of symptomatology, and an increase in overall physical health and financial stability (Arnold, Walsh, Oldham, & Rapp, 2007; Macias et al, 1994).

Other benefits of strengths-based case management supports include increased service satisfaction and utilization, improved hopefulness regarding recovery, increased feelings of well-being, more social supports, and positive employment outcomes (Bigelow & Young, 1991; Macias, Farley, Jackson, & Kinney, 1997; Siegal et al., 1995a). Therefore, research examining different case management approaches does yield evidence in support of the effectiveness of

case management models, including strengths-based case management models (Vanderplasschen, Wolf, Rapp, & Broekaert, 2007). Research on Rapp & Goscha's (2012) SBCM Service Delivery Model with persons with a dual diagnosis is highly recommended.

Despite the benefits of strengths-based case management, Staudt, Howard, & Drake (2001) warn of the inherent challenge for research to validate the effectiveness of strengths-based case management efforts when the integral components of the model are not unique to strengths-based case management service delivery. Furthermore, Hangan (2006) highlights that if case management supports were truly effective, there would be no hospital readmissions by persons who received such supports. Ziguras & Stuart (2000) argue that the effectiveness of intensive case management approaches is ultimately correlated to the availability of variable community resources, funding and staff skill set. In fact, Ibrahim et al. (2014) found that there was no effect in levels of functioning and quality of life, in adults with severe mental illness, when engaged in strengths-based service delivery. Regardless of these reservations, strengths-based case management models identify talents, capabilities and skills in each person, which can contribute positively to a client's growth (Francis, 2014; Saleebey, 1996).

Organization structure and leadership. Organization X promotes a liberal philosophy, evidenced within the vision, values and mission statement, yet holds a conservative, organizational structure. Organization X has a functional organizational structure (Galbraith, 2014). The vertical hierarchy within the organization is divided into an array of functional departments, further subdivided into client-need cohorts, like Service N (Galbraith, 2014). The functional organizational structure is further evidenced by the standardized application of Rapp & Goscha's (2012) SBCM Service Delivery Model throughout the organization (Galbraith, 2014). Within the conservative hierarchal structure, lies assigned leadership roles,

responsibilities and decision-making power (Gutek, 1997). More specifically, decision-making power resides with the Executive Director and Board of Directors, filtering down through senior and middle management, clinicians and then to the clients.

The leadership team within the organization consists of both managers and leaders. Senior and middle managers are responsible for operational tasks including planning, administrative tasks, budgeting and problem solving (Northouse, 2019). These managers are expected to be directive, achievement oriented, authority-compliant leaders, focused on outcome measures. However, with a mission and vision to lead social change efforts and challenge mental health stigma, the senior and middle managers must also build teams, inspire others and empower followers and clients (Northouse, 2019).

Political, economic, social, and cultural contexts. Sullivan et al. (2011) explain that persons with developmental disabilities have complex health issues, which can include mental health challenges. The Ontario Ombudsman Report (2016) addresses the need for persons with developmental disabilities to obtain accurate assessment, diagnosis and receive evidence-informed treatment and supports. Since Ontario embraced deinstitutionalization of persons with developmental disabilities in the 1980s, there has been a policy shift towards more community-based supports (Lemay, 2009; Ontario Ombudsman's Report, 2016). With more readily available community supports, like case management services, repeated emergency room visits, and lengthy hospitalizations could be avoided (Ontario Ombudsman's Report, 2016). Therefore, effective case management supports are a critical function in the developmental disabilities sector (Durbin, Sirotich, Lunsy, & Durbin, 2017).

The aim of deinstitutionalization was to improve the quality of life of persons with intellectual disabilities (Chowdhury & Benson, 2011). Unfortunately, persons with

developmental disabilities do not have equitable access to healthcare, or receive the same quality or levels of service due to barriers which can include communication difficulties, misdiagnosis, inappropriate interventions and knowledge gaps by professionals providing services (Griffiths, Stavrakaki, & Summers, 2002). Consequently, due to inadequate community supports, when a person with a dual diagnosis requires support for mental health challenges, they are often hospitalized for lengthy periods of time, increasing the cost and strain on the Ontario health care system (Lunsky & Balogh, 2010). Therefore, efficient case management services for persons with a dual diagnosis are necessary and further highlights the importance of examining this POP.

Role and responsibility within the organization. Mental health programs must continually evolve to include the latest service innovations to meet client needs (Corrigan & Garman, 1999). The Program Manager has a variety of roles and responsibilities within Organization X to support these service innovations. It is within the scope and agency of the Program Manager to make changes to ensure adequate service delivery and fidelity to Rapp & Goscha's (2012) SBCM Service Delivery Model. Agency refers to the capacity to make a difference or have influence within a setting (Frost, 2006). The Program Manager relies on fidelity measures; assessment tools which gauge how successfully a program model was implemented within a new environment (Bond, Evans, Salyers, Williams, & Kim, 2000). Within Organization X, all programs are to use Rapp & Goscha's (2012) SBCM Service Delivery Model, given endorsement by internal and external stakeholders.

Fidelity to Rapp & Goscha's (2012) SBCM Service Delivery Model and subsequent high-fidelity measures require implementation of the model's principles, methods, and unique tools to deliver strengths-based, intensive case management support. Two such tools are the Strengths Assessment and Personal Recovery Plan (Rapp & Goscha, 2012) and are available in

Appendices A & B. The answers provided by the clients on these two tools are scored. More accurate information equates to higher scores. These scores determine whether the client continues to receive intensive case management support. If a client is able to self identify goals and actionable steps towards goal attainment on these tools, the client scores high on the fidelity measure and receives continued case management support from Service N clinicians. With low fidelity scores on the Strengths Assessment and Personal Recovery Plan, it is within the scope and agency of the Program Manager to close the client's file. With a comprehensive understanding of the Program Manager's scope and agency, the next section will explore the interplay of the Program Manager's leadership position within Organization X.

Leadership Position and Lens Statement

Hogan & Kaiser (2005) described "who we are is how we lead" (p.170). As an emergent leader, I feel my core values and behaviors display respect, honesty, integrity, emotional intelligence, inclusivity, empathy, and self-awareness, which are foundational to my leadership style. I am liberal in my beliefs, promoting individuality, creativity, social awareness and autonomy (Day, Fiske, Downing, & Trail, 2014; Skitka & Tetlock, 1993). I view the world from a constructivist, disability lens (Creswell, 2007; Gilson & DePoy, 2002; Grenier, 2006). Thus, having a disability is not perceived as a personal defect requiring hospitalization or institutionalization, but as a uniquely strong, positive, individual trait (Anastasiou & Kauffman, 2011; Creswell, 2007). I believe that egalitarianism is achievable through social change for persons with disabilities. Creswell's (2007) opinion that researchers need to explicitly identify theoretical biases to highlight assumptions based on one's worldviews, can be extended to scholarly practitioners. Therefore, I acknowledge that my leadership philosophy and core values do influence this OIP and POP.

As Program Manager, I am integral in fostering an organizational culture of accountability, community, innovation, and leadership through open communication and ethical behavior. My leadership behaviors align with my values and beliefs, authentically. I am invested in building and maintaining formal and informal relationships with others throughout the organization, in particular with the clinicians in Service N. I am proud of the partnerships I have made with internal and external stakeholders. By implementing the contents of this OIP, I can envision the future of Organization X engaging, developing, and better supporting strengths-based, intensive, case management supports to persons with a dual diagnosis.

In summary, my personal leadership style, core values, and beliefs describe essential components of transformational leadership. Originally developed by Burns (1978) and expanded upon by Bass (1985), transformational leadership is a theory that describes how interpersonal connections between a leader and followers positively impact motivation and morality (Hassan, Jati, Majid, & Ahman, 2019; Northouse, 2019). Transformational leadership employs leadership influence to move followers from self interest to commitment of an organization's mission (Jaskyte, 2004; Northouse, 2019; Stone, Russell, & Patterson, 2004). The personal morals, values, beliefs and qualities of the leader helps elicit effort and commitment from followers, as emotions and motivation are attended to respectfully and with dignity (Hassan, Jati, Majid, & Ahman, 2019).

Bass, Avolio, Jung, & Berson (2003) explain how transformational leadership is more likely to emerge when organizations are experiencing distress and change, thus supporting transformational leadership as the dominant leadership style required to drive change within Organization X. Currently, the clinicians within Service N are displaying resistance in using Rapp & Goscha's (2012) SBCM Service Delivery Model. Transformational leaders challenge

organizational systems to create new programs, process and services (Jaskyte, 2004).

Personality and leadership skills help the transformational leader encourage followers to critically evaluate organizational services and to think innovatively about program improvements (Corrigan & Garman, 1999). The two solutions to the POP, explored within Chapter Two, can address resistance, inspire innovation, and help create a new organizational process.

Transformational leadership is comprised of four essential elements; idealized influence, inspirational motivation, individualized consideration, and intellectual stimulation (Bass & Avolio, 1994; Dionne, Yammarino, Atwater, & Spangler, 2004; Mary, 2005; Northouse, 2019). Figure 1.1 depicts these four transformational leadership components, identifying the influence of a leader's personality traits and behaviors on followers. Briefly, idealized influence includes the charismatic personality traits of the leader, who builds trust amongst followers by role modelling expectations (Bass & Avolio, 1994; Dionne et al., 2004; Jaskyte, 2004). Inspirational motivation includes articulating a vision through clear, effective communication to inspire a sense of purpose and confidence (Bass & Avolio, 1994; Corrigan & Garman, 1999; Jaskyte, 2004). Individual consideration involves an investment in a follower by attending to needs and providing opportunities to utilize skills and explore interests (Bass & Avolio, 1994; Corrigan & Garman, 1999; Jaskyte, 2004). Intellectual stimulation challenges followers to identify innovative and creative solutions and builds team cohesion through involvement in decision making (Bass & Avolio, 1994; Corrigan & Garman, 1999; Dionne et al., 2004). These four essential transformational components help form a committed partnership between the leader and followers (Jaskyte, 2004).

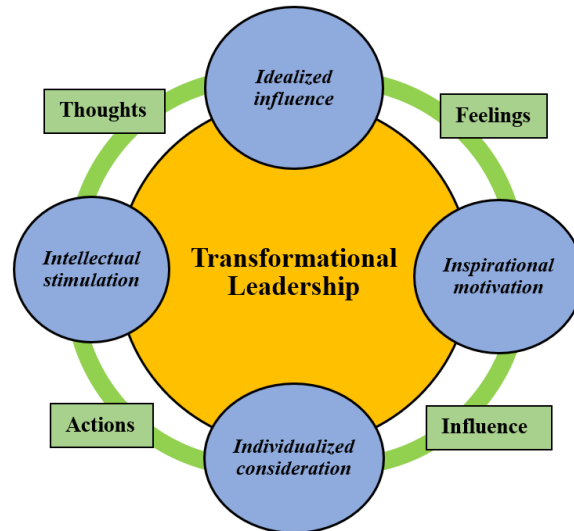


Figure 1.1. Transformational leadership’s four essential components. Adapted from “Transformational leadership and organizational culture” by B. M. Bass & B. J. Avolio, 1994, *International Journal of Public Administration*, *International Journal of Public Administration*, 17(3-4), p. 541.

Mental health services must continually evolve to include the latest service innovations to address the constantly changing needs of clients (Corrigan & Garman, 1999). Leaders who adopt transformational leadership can help create a cohesive and motivated team, that can inspire program enhancements (Corrigan & Garman, 1999). However, transformational leadership does assume that leaders and followers share common goals. It is possible that follower motivation may occur independent of the leader (Barnett & McCormick, 2003). Nonetheless, as the Program Manager of Service N, adopting and embracing transformational leadership is critical to this OIP since it seeks to address resistance to the Rapp & Goscha’s (2012) SBCM Service Delivery Model by enhancing certain components of model for use with clients who have a dual diagnosis.

Leadership Problem of Practice

The POP statement, essential to this OIP proposal, questions what leadership theories and frameworks could address the resistance within Service N in adopting Rapp & Goscha's (2012) Strengths Based Case Management Service Delivery Model. Despite the plethora of research supporting how Rapp & Goscha's (2012) SBCM Service Delivery Model helps support persons with psychiatric illnesses (Arnold, Walsh, Oldham, & Rapp, 2007; Bigelow & Young, 1991; Francis, 2014; Macias, Kenney, Farley, Jackson, & Vos, 1994; Siegal et al., 1995a; Vanderplasschen, Wolf, Rapp, & Broekaert, 2007), research has not been conducted on the applicability of this model with persons with a dual diagnosis. To review, since 2016, internal data, client satisfaction surveys, low fidelity scores, and tacit knowledge yielded challenges using this model with persons with a dual diagnosis. One premise of Rapp & Goscha's (2012) SBCM Service Delivery Model is an outcome where individuals make meaningful connections with naturally occurring resources in their communities to support positive mental wellness, and a movement away from formalized, patient-centered settings (Burns & Rapp, 2001; Rapp, 2014). Therefore, within Organization X, this service delivery outcome could be reflected in statistics denoting a higher turnover rate of clients entering and exiting service, as they are receiving community supports to help manage their mental illness instead of Organization's X formal support.

Table 1.1 indicates how Organization X saw an overall increase in the number of clients served by 5% in 2016/2017 and an additional 7% in 2017/2018 compared to the number of clients served in 2015/2016, excluding data from Service N. Therefore, more clients received services for mental health challenges, more connections were made with community resources, indicating a possible increase in client autonomy and self-efficacy (Rapp & Goscha, 2012).

However, clients with a dual diagnosis within Service N did not see a similar statistical outcome. In fact, as Table 1.1 indicates, since the Rapp & Goscha (2012) SBCM Service Delivery Model was implemented, Organization X has experienced a decrease in the number of clients served in 2016/2017 and 2017/2018. This suggests that clients within Service N were staying in service longer, decreasing the number of possible intakes into Service N as a result of fewer caseload vacancies. Without support from Service N, persons with a dual diagnosis are less likely to make connections with naturally occurring resources, and more likely to rely on formalized supports for mental wellness.

Table 1.1

Total number of unique clients within Organization X and Service N, between 2014-2018, pre and post implementation of Rapp & Goscha's (2012) SBCM Service Delivery Model.

	2014/2015	2015/2016	2016/2017*	2017/2018
Unique clients within the organization	1320	1342	1406	1432
Unique clients within Service N	73	70	63	58

Note. Highlighted column* identifies year of SBCM Service Delivery Model implementation. Adapted from *Intake statistics 2015-2018*, by Organization X, 2018b (Internal Statistics). Unpublished data.

To summarize, Rapp & Goscha's (2012) SBCM Service Delivery Model highlighted challenges for both the clients and clinicians within Service N. Clients self-reported difficulty understanding the language, abstract concepts, and in recalling historical information required by the Strengths Assessment and Personal Recovery Plans, as seen in Appendices A & B. Consequently, this resulted in lower fidelity scores on these tools and may have prompted premature file closures. Clinicians reported filling out the Strengths Assessment and Personal Recovery Plans for clients, which has moral and ethical implications. This behavior also

violated fidelity expectations to the service delivery model. Furthermore, clinician testimonials explained how they were working with clients for longer durations, maintaining these clients on the clinician caseload for longer periods of time in an effort to progress clients through the service delivery model, without yielding an increase in goal attainment. The effort of trying to assist and support clients using this model translated into less clients receiving support.

Therefore, it appears these challenges may have contributed to cognitive, affective and behavioral resistance (Aarons & Sawitzky, 2006; Erwin & Garman, 2010; Kebapci & Erkal, 2009) by the clinicians within Service N, towards the strengths-based intensive case management service delivery model. Erwin & Garman (2010) define behavioral resistance as relating to how individuals behave in response to change, cognitive resistance as what individuals think about the change, and affective resistance as how individuals feel about change. This resistance will be further explored throughout the remainder of this OIP as it is an important element within the POP.

Gap between current and future organizational state. In 2016, senior management, the Executive Director and Board of Directors fully supported moving to a strengths-based, intensive case management service delivery model. Adoption of Rapp & Goscha's (2012) SBCM Service Delivery Model met the organization's strategic goals and provincial mandates by providing more intensive case management support to clients. With increased client autonomy and community connections, it was anticipated that clients would present less to the emergency room to receive mental health support and incur fewer hospitalizations due to mental health challenges (Organization X, 2017). Favorable metrics using this strengths-based case management approach may secure future funding from the ministry.

Strengths-based case management models assume that individuals have the level of functioning ability to allow them to participate in goal setting, community resource knowledge acquisition, and engage actively with others in the community (Gaboda, 1999). This may not be the case for persons with a dual diagnosis, creating an inherent challenge applying this model to this cohort of individuals. Table 1.2 indicates fidelity scores for clients within Service N, over a three-year period. Overall, the fidelity scores were poor and did not meet the criteria for high fidelity throughout the three-year period. The clinicians struggled to implement the tools within the model. In fact, results show that Strengths Assessments were used less than 60% of the time.

Table 1.2

Fidelity scores for clients within Service N in 2016, 2017, and 2018.

Rated item	<u>Service N fidelity scores (%)</u>		
	2016	2017	2018
Evidence that the Strengths Assessment is used regularly within interactions with client clinician	< 60	< 70	< 70
Client language is used and it is clear that the client was involved in the development of the Strengths Assessment	< 60	< 60	< 60
Personal Recovery Plan goals are broken down into smaller measureable steps by the client	60-74	60-74	60-74
Goals on the Personal Recovery Plan use client's own language, actual passion statement, and state why the goal is important	< 44	45-59	45-59
Evidence that more naturally occurring resources are used more often than formal mental health resources	11-25	26-40	26-40

Note. High fidelity is >90% for all items, except for last row (evidence that more naturally occurring resources are used more often than formal mental health resources) when high fidelity is >75%. All scores are represented as percentages. Adapted from *Strengths Model, Project Leader's Workbook*, by Rapp, C. Copyright 2014 by Kansas University Press.

The low fidelity scores in Table 1.2 support testimonials by both clinicians and Service N clients that these clients struggled to comprehend the material and struggled with recalling information to score higher on the Strengths Assessment and Personal Recovery Plan. The more thorough the completion of the assessment tools, the higher the fidelity score. However, the answers provided by Service N clients on these tools were either absent or clearly indicated they were unable to self identify goals, steps on achieving goals, and lacked of knowledge about community resources resulting in lower fidelity scores and goal attainment.

The Program Manager is solely responsible to review Rapp & Goscha's (2012) SBCM Service Delivery Model tools and assessments and quantitatively evaluate client goals, level of participation in service and termination timelines based on fidelity scores. The low fidelity scores lead to an increase in file closures within Service. Based on these challenges, it appears that having a dual diagnosis introduces possible mitigating factors that need to be considered. When the community is unable to support the mental health needs of persons with an intellectual disability, support is sought within hospital emergency rooms (Griffiths, Stavrakaki, & Summers, 2002). Therefore, with such poor service delivery outcomes for clients with a dual diagnosis, it is understandable why there was resistance in adopting Rapp & Goscha's (2012) SBCM Service Delivery Model.

The future organizational state would involve two strategic solutions aimed at reducing the resistance from the clinicians in using this particular service delivery model. First, the involvement of family and caregivers would provide an opportunity to gather information on the assessment tools, resulting in higher fidelity scores. Second, differentiated capacity building would increase clinician autonomy to augment the Strengths Assessment and Personal Recovery Plan according to the unique learning needs of each client. Each of these solutions will be more

fully explored within Chapter Two of this OIP. Additionally, the future organizational state would increase clinician autonomy and client goal attainment, and decrease resistance expressed by the clinicians within Service N. The Program Manager's future vision of Organization X, as viewed through a constructivist, disability lens (Gilson & Depoy, 2002; Grenier, 2006) aligns well with the strategic goals of the organization; to deliver case management supports with positive outcomes for each client.

Framing the Problem of Practice

Historical overview of the problem of practice. Since the 1980s, the Canadian Federal Government has promoted the deinstitutionalization of persons with developmental disabilities to community-based support services (Lemay, 2009). The purpose of deinstitutionalization was to improve the quality of life for persons with intellectual disabilities (Chowdhury & Benson, 2011). An outcome of deinstitutionalization was the shift in some health care responsibilities from hospitals to community-based supports (Durbin, Sirotich, Lunskey, & Durbin, 2017). However, following deinstitutionalization, persons with intellectual disabilities did not have equal access to health care, receive the same quality or level of service and many of their needs remained unmet in the community (Griffiths, Stavrakaki, & Summers, 2002). Challenges arose when accessing community supports, impacted by communication difficulties, misdiagnosis, inappropriate interventions and knowledge gaps by professionals serving this population (Griffiths, Stavrakaki, & Summers, 2002). These challenges contribute to ineffective community supports and hospital admissions are often sought for mental health issues (Lunskey & Balogh, 2010). When hospitalized, persons with a dual diagnosis compared to other patients yield longer hospital stays, have more severe symptoms, and medical comorbidities with fewer personal

resources and external supports (Lunsky & Balogh, 2010). These situations challenge the very intent of deinstitutionalization.

The Canadian Human Rights Act and the Canadian Charter of Rights and Freedoms, protect the rights of persons with disabilities (Human Rights and Disabilities, 2009). However, within Canada, there are no national guidelines on how to access and treat the mental health needs of persons with developmental disabilities (Lunsky, Garcin, Morin, Cobigo, & Bradley, 2007). Services for individuals with intellectual disabilities are provincially based, and financial allocations are regionally determined (Gough & Morris, 2012; Lunsky, Garcin, Morin, Cobigo, & Bradley, 2007). Therefore, ministries and municipalities in Ontario vary greatly on the degree of organization, coordination and implementation of community care for people with developmental and mental health challenges (Durbin, Sirotich, Lunsky, & Durbin, 2017; Lunsky, Garcin, Morin, Cobigo, & Bradley, 2007). These challenges further exacerbate and complicate access to community support services for persons with a dual diagnosis.

Results from the 2017 Canadian Survey on disability, as depicted in Table 1.3, show an increase in the Canadian population and increases in the number of Canadians reporting a disability, mental health related disability and developmental disability, compared to the 2012 Canadian Survey on disability (Statistic Canada, 2012, 2018). Furthermore, the statistics describe an increased likelihood of persons who disclosed having a disability also reporting having two, three, or more concurrent disabilities (Statistics Canada, 2018). With Canadian statistics reporting increasing rates of all disabilities, community supports are necessary to support individuals within the community, and to divert them from hospital resources (Griffiths, Stavrakaki, & Summers, 2002). The Ontario Ombudsman Report (2016) claimed repeated emergency visits and lengthy hospitalizations could be reduced or avoided if there were more

extensive outpatient-based mental health supports for those persons with a dual diagnosis.

Organization X provides the majority of community support for persons with mental health challenges and intellectual disabilities, in the area. Therefore, it is important that Organization X offer case management support tailored to the special needs of individuals with a dual diagnosis.

Table 1.3

Prevalence of disabilities reported within Canada in 2012 and 2017

Total number of Canadians	Canadian Population Totals 2012	Percentage (%) of Canadian Population Totals 2012	Canadian Population Totals 2017	Percentage (%) of Canadian Population Totals 2017
	27,561,313		28,008,860	
Reporting a disability	3,775,900	13.7	6,246,640	22.3
Reporting a mental health related disability	1,059,600	3.8	2,027,370	7.2
Reporting a developmental disability	160,500	.6	315,470	1.1

Note. Adapted from *Canadian survey on disability, 2012: Developmental disabilities among Canadians aged 15 years and older, 2012*, by Statistics Canada and *Canadian survey on disability, 2017, Types of disability for persons with disabilities aged 15 years and over, by age, group and sex, Canadian Provinces and Territories*, by Statistics Canada.

Key organizational frameworks. Bolman & Deal (2013) provide a Four-Frame Model as a method for considering change initiatives. This Four-Frame Model encourages leaders to examine an organization through four distinct perspectives (Bolman & Deal, 2013). Understanding the organization more broadly helps to analyze and assess potential solutions to organizational problems (Bolman & Deal, 2013). Accordingly, to understand the complexities

of the organizational resistance within Service N, the POP will be considered through Bolman & Deal's (2013, 2014) Structural, Human Resources, Political and Symbolic frame.

When the POP is considered through the Structural Frame, challenges become apparent. The structural frame focuses on the alignment between structures and processes within an organization (Haviland, 2014). One such structure is the formal structure of a team within an organization (Bolman & Deal, 2013, 2014). The team configuration within Service N is hierarchical, consisting of a one-boss arrangement whereby the Program Manager has the decision-making authority over file closures based on fidelity scores and internal metrics (Bolman & Deal, 2013). Service N clinicians report a desire for horizontal decision-making, yet are bound by top-down, decision-making structure. Another dimension for consideration concerns investment and developing human capital within an organization, while maximizing the division of labor (Haviland, 2014). With the introduction of Rapp & Goscha's (2012) SBCM Service Delivery Model, came an increase in workload, data collection, assessments and evaluations required for fidelity to the model. No additional staff personnel were available to contend with the influx of qualitative and quantitative data collection and analysis. Within Service N, these additional responsibilities became additional tasks for the clinicians. The workload was further compounded by the absence of standard operating procedures and training on how to deliver this service delivery model to persons with a dual diagnosis. Therefore, when considered through the structural frame, a misalignment between structures and processes becomes evident.

When considered through a Human Resource Frame, the fit between Service N and the organization is strained. This frame focuses on the importance of collaboration, encouraging autonomy, participation, belonging and meaning (Bolman & Deal, 2013; Sasnett & Ross, 2007).

The focus of Rapp & Goscha's (2012) SBCM Service Delivery Model is individualized goal attainment, yet the applications and fidelity measures are standardized throughout the organization. Lovaas (2003) advocates that persons with intellectual disabilities require individual, tailored support plans to optimize success which can not be met following standardized practices. Additionally, this frame highlights the misalignment of liberal views expressed within the organization's mission, vision, and values with the conservative leadership approach. Furthermore, tacit knowledge reveals that Service N clinicians feel insignificant and invisible within the large organization, as they are the smallest team within the organization and no designated office space. Therefore, the Human Resource frame emphasizes a strained fit within the organization.

When considered through the Political Frame, the needs of stakeholders and engagement practices with service partners are paramount (Bolman & Deal, 2013; Haviland, 2014). Rapp & Goscha's (2012) SBCM Service Delivery Model requires individuals to build a support system of naturally occurring supports to help assist with mental wellness and psychiatric recovery (Rapp and Goscha, 2012). However, a current-state analysis of external resources was absent, prior to implementation. In fact, external community partners were not informed of changes in service delivery model, despite an unknowing expectation to participate. If external resources are being identified and included in support plans unknowingly, this has both political and ethical change process implications. Therefore, this frame highlights a gap in communication and implementation strategies with external stakeholders.

When considered through the Symbolic Frame, challenges arise. The Symbolic Frame acknowledges the importance of organizational culture by aligning organizational history, values and change initiatives while also emphasizing the importance of culture and meaning making

(Bolman & Deal, 2013). It is important that the clinicians feel they are involved in meaningful work and are contributing to a positive organizational culture. Bolman & Deal (2014) explain that groups unify through words, phrases and metaphors unique to situations. However, the clinicians were unsuccessful using the words, concepts, and phrases on the Strengths Assessment and Personal Recovery Plans with the clients, as the clients appeared to struggle with the material and completion of the assessments. It appeared that regardless of the effort the clinicians put forth completing the Strengths Assessment and Personal Recovery Plans with the clients, the fidelity scores were low and client files were being closed prior to goal attainment. The symbolic frame also stresses the importance of rituals and ceremonies (Bolman & Deal, 2013). With the introduction of Rapp & Goscha's (2012) SBCM Service Delivery Model, the weekly resource team meeting became a more focused discussion about strengths and community resources and clinicians lost team meeting time, which typically was an avenue to discuss various topics, agency information, share stories, request assistance for clients. This may have impacted team building efforts (Bolman & Deal, 2014). Therefore, the Symbolic Frame affirms additional challenges within Organization X.

Bolman & Deal's (2013) Four-Frame Model requires a balanced perspective among components of the model (Thompson et al., 2008). However, some leaders function in only two or three frames rather than perceiving organizational problems through all four frames (Thompson et al., 2008). This may be correlated with a leader's knowledge or experience (Thompson, 2000). Therefore, for Bolman & Deal's (2013) model to be effective in understanding the POP, a leader must be aware of all four perspectives and possess the skill set to apply each frame effectively to an organizational problem (McArdle, 2013; Thompson, 2000; Thompson et al., 2008). Nonetheless, Bolman & Deal's (2013) Four-Frame Model does encourage a broader

perspective to consider organizational problems and solutions. This model does highlights numerous challenges that could impact the resistance within Service N in adopting Rapp & Goscha's (2013) SBCM Service Delivery Model.

PESTE analysis. To consider the POP utilizing a political, economic, social, technological and environmental (PESTE) analysis provides insight into the influences that drive the need for change (Cawsey et al., 2016). Each of these factors will be described. Political factors influence the organization, its structures, operations and leadership. It is important to consider the interplay of the ministry and municipal departments and how these political factors can impact on Organization X. Cutbacks to the Ontario Disability Support Program and a pending definition change to 'disability' may negatively impact clients' financial capability. An inability to acquire resources is a necessary component of Rapp & Goscha's (2012) SBCM Service Delivery Model. Without resources, such as a bus pass or cell phone, the client may experience further challenges accessing naturally occurring resources and achieving goal attainment.

Economic factors include an uncertainty regarding fiscal investment in Organization X. The funding envelope for non-profit organizations may be impacted by the current government agenda. Developmental support agencies are dependent on this funding envelope, including Organization X. Without economic investment in community supports and resources, vulnerable populations could be severely and negatively impacted. Additionally, the Program Manager and clinicians within Service N were hopeful that the program would expand to meet the increasing need for support. However, the interplay of political and economic factors creates doubt for program expansion. With a reliance on government and municipal funding to operate, economic factors do exert scope, agency and influence over Organization X.

Societal factors help drive the need for change. One such societal factor is stigma. Mental illness stigma is compounded by other factors like having an intellectual disability or being marginalized. Another societal factor is infrastructure. The urban city where Organization X operates has infrastructure challenges that negatively affect public transportation which also affect resources within the community, including travelling to Organization X. Each of these societal factors help address the need for change.

In addition to the political, economic and social factors impacting on the POP, the use and access to technology is a necessity for clinicians and clients. Technology is required to communicate with clients, fellow clinicians, external partners and leaders within the organization. Technology and an expanding data base are required to help manage the influx of personal health information, referrals, assessments, and summary notes as an outcome of Rapp & Goscha's (2012) SBCM Service Delivery Model. Clinicians are required to navigate technological cell phone and iPad upgrades and applications to perform job requirements. However, a technology-related barrier exists for clients. It is assumed that clients can afford and have access to a cell phone, internet, and a computer or can operate technological devices, which may not be the case. The increasing need for technology highlights challenges within the organization and potential barriers for clients to access and operate technology.

A final factor to consider is the environment. Clinicians meet with clients in an array of community venues which include coffee shops, schools, family homes and at the office. Each setting is different, with its own vast array of competing noises and visual stimuli. These stimuli can negatively affect a client's frustration tolerance, attention and concentration abilities. Community venues may highlight confidentiality issues as delivery of services occur within community settings

In summary there are a number of political, economic, social, technological and environmental influences that exert influence on Organization X, clinicians and clients. Each of these factors provide insight into what drives the need for organizational change.

Guiding Questions Emerging from the Problem of Practice

When considering leadership theories and frameworks to address resistance within Service N in adopting Rapp & Goscha's (2012) SBCM Service Delivery Model, numerous questions arise. Within this OIP, the guiding questions emerging from the POP will be considered from a macro, meso and micro level perspective. Although it is outside the scope and agency of the Program Manager to influence macro level considerations, it is important to emphasize these influential factors on the POP.

Macro level perspective. From a macro level perspective, the OIP highlights the need for effective community-based support services for persons with developmental disabilities (Griffiths, Stravakaki, & Summers, 2002; Lemay, 2009; Ontario Ombudsman's Report, 2016; Sullivan et al., 2011). Questions arise whether there exist adequate community resources for persons with a dual diagnosis and where fiscal responsibility reside. Furthermore, this OIP queries how to support mental health concerns for those with a dual diagnosis as there are no national guidelines on how to access and treat this population's mental health needs (Lunsky et al., 2007). Canadian researchers Lunsky et al. (2012) reported persons with a dual diagnosis fail to have their complex needs met by outpatient care providers. This questions whether the absence or lack of adequate and appropriate community services correlates to longer inpatient hospitalizations for persons with a dual diagnosis. Furthermore, Lunsky et al. (2007) posit the need for an environmental scan of developmental sector services across Canada to help inventory

services and barriers which exist for this population. In summary, there are numerous macro level queries that emerge from the POP.

Meso level perspective. Considering the POP from a meso perspective, additional questions arise. Of utmost importance to this OIP is whether strengths-based, intensive case management can support clients with a dual diagnosis. Rapp & Goscha's (2012) SBCM Service Delivery Model remains untested within the developmental disability sector (Saleebey, 2009). Furthermore, various researchers have concerns about general strengths-based case management models highlighting the lack of training for clinicians, the disregard for challenges that affect well being, and lack of community resources affecting service delivery outcomes (Ibrahim, Michail, & Callighan, 2014; Saleebey, 1996; Tse et al., 2016). With questions arising about the applicability of this form of intensive case management support, it is within the scope and agency of the Program Manager to find solutions within the parameters of Rapp & Goscha's (2012) SBCM Service Delivery Model which may have the positive outcome of reducing resistance towards the model.

Micro level perspective. At the micro level, consideration for individualized case management support should be explored. Gilmore, Campbell, & Shochet (2016) suggest that students with developmental disabilities benefit from individualized, modified, school-based interventions. Explored within Chapter 2 of this OIP is a school-influenced solution, introduced as differentiated capacity building which is a micro level intervention that is similar to educational interventions. Additional micro level considerations include questions about fidelity, clinician performance and motivation levels which may be contributing to resistance towards the model. Most important are the clients and whether they feel Rapp & Goscha's (2012) SBCM Service Delivery Model is assisting in their recovery.

In summary, it is important to explore macro, meso and micro level factors influencing the POP. Each of these factors help to substantiate the importance of the POP, by highlighting points of interest to consider when implementing an organizational change effort.

Leadership-Focused Vision for Change

Gap between present and future state. My vision for change as a leader within Organization X complements my optimistic, authentic, leadership style. Currently Organization X is experiencing behavioral, cognitive and affective resistance (Erwin & Garman, 2009) from the clinicians within Service N, affecting the adoption of Rapp & Goscha's (2012) SBCM Service Delivery Model. Four future outcomes will be discussed.

First, the future outcome of the proposed organization change effort will include viable and accepted solutions within the parameters of using Rapp & Goscha's (2012) SBCM Service Delivery Model. Such a future outcome serves multiple stakeholders within Organization X. Not only does it benefit persons with a dual diagnosis, but it may also improve strengths-based, intensive case management service delivery throughout the organization, supporting all clients.

Second, a decrease or elimination of resistance by the clinicians within Service N, would indicate that the organizational change effort successfully addressed the necessary areas for change. Therefore, successful adoption of Rapp & Goscha's (2012) SBCM Service Delivery Model within Service N is paramount in any future organizational change effort with Organization X.

Third, having clients better utilize naturally occurring community resources would have both individual and societal benefits. For example, on a micro level, the clients with a dual diagnosis would have an increased number of community supports. Additionally, these naturally occurring community resources may be used prior to the emergency room when a crisis arises.

This future state could be more easily achieved if a client's family member or caregiver were given an opportunity to participate in the assessment process and acquire knowledge of community resources through completion of the Strengths Assessment and Personal Recovery Plan. Within Chapter Two, this solution to the POP is further explored.

The last future outcome is the increased ability for clients to better participate in their mental health care by providing tailored learning and support material, better suited to their individual learning needs. Utilizing differentiated capacity building may help to support client learning, clinician autonomy, and build skills for clients to better manage their mental health needs independently. Again, this solution to the POP will be further explored within Chapter Two.

Priorities for change. There exist three priorities for change to consider within the POP. The first priority is to increase the knowledge and understanding of service delivery and community supports for persons with a dual diagnosis. It is paramount that the clinicians have specialized knowledge when working with clients who have a dual diagnosis (Werner & Stawski, 2011). This specialized knowledge can then be shared amongst the team and with family members and caregivers. A second priority involves collaborating with family and caregivers of clients, to help obtain information necessary for completion of the Strengths Assessment and Personal Recovery Plans. Presently, if a client is unable to recall or understand information on these assessments, the client receives a lower fidelity score. This can lead to premature file closures and fewer achieved goals. If family members and caregivers are permitted to participate in the assessments process and this secondary information is scored as primary information on these assessments, this could help mitigate premature file closures and may increase goal attainment. A third priority involves using differentiated capacity building to

augment the Strengths Assessment and Personal Recovery Plan to adapt the delivery of the material to the learning needs of each client. Furthermore, it is possible that other clients within Organization X could benefit from family and caregiver involvement and differentiated capacity building activities, such as clients with an acquired brain injury or chronic substance use.

In summary, the creation of an environment that supports individual strengths and capacity could enhance client outcomes while simultaneously providing mental health support. Transformational leadership can help drive this change initiative and helps promote the urgency of this change initiative.

Change drivers. Whelan-Berry, Gordon, & Hinings (2003) define change drivers as essential influences within the change process. Cawsey et al. (2016) explain that change drivers are considered change implementers and can empower others and help facilitate movement within the change process. There exist numerous change drivers at macro, meso and micro levels that can support the change process, each establishing the context in which organizational change occurs (Anderson & Ackerman Anderson, 2010). Figure 1.2 introduces the change drivers influencing Organization X's transformation.

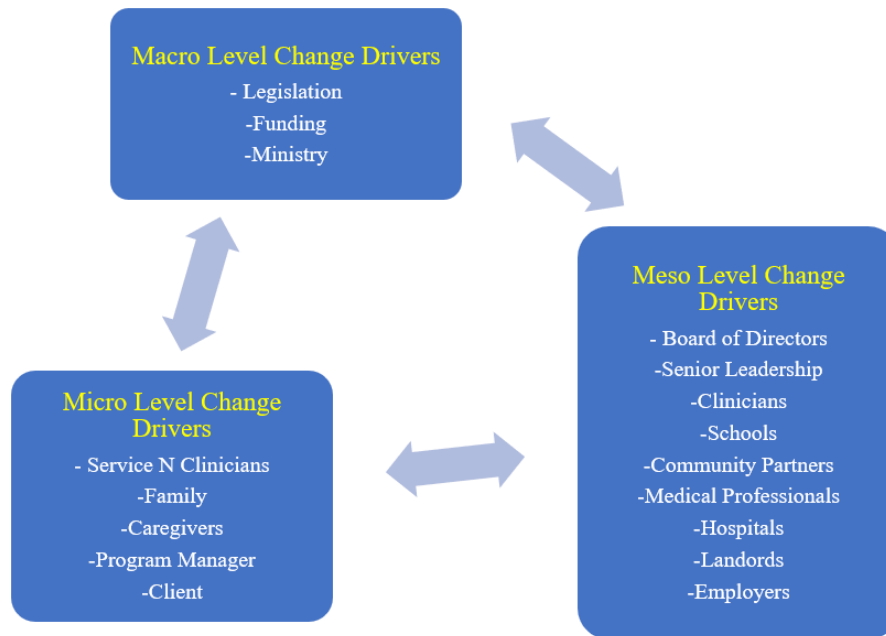


Figure 1.2. Macro, Meso and Micro level change drivers influencing Organization X's change transformation.

At a macro level, change drivers may include legislative and ministry influencers and federal and provincial health care legislation. These macro level change drivers could fund community supports and could provide additional funding to Organization X to increase service delivery capacity. At a meso level, the Board of Directors, senior leadership and other clinicians within the organization would be considered change facilitators. These meso level change drivers are instrumental in helping to promote and communicate the organizational change through transformational leadership efforts. Without meso level influencers, it would be very difficult to implement any organizational change. Community partners, schools, medical professionals, hospitals, landlords, employers and various other resources, as identified within Rapp & Goscha's (2012) Strengths Assessment and Personal Recovery Plans, may also act as meso level change drivers. These influencers could provide support to clients and within the community. At a micro level, clinicians, families and caregivers are influential change drivers. Using transformational leadership, the Program Manager is also an instrumental vessel for

change communication, implementation and motivation. Most importantly, the primary stakeholder is the client. The client must benefit from improvements in service delivery. Each of the aforementioned macro, meso and micro change drivers can influence each other. Thus, it is important that all change drivers partner to transform the organization. (Ackerman Anderson & Anderson, 2010). In Chapter Three, a communication plan outlining the collaboration of the change drivers is explored.

Organizational Change Readiness

Knowing where one is presently, positions oneself for knowing where to go in the future. Hence, understanding the need for change and possessing a vision for the future state are closely related (Blackman, O'Flynn, & Ugyel, 2013; Cawsey et al., 2016). Since organizational change is a continuous process of assessment, monitoring and evaluation, assessing for organizational change readiness is an important first step in this iterative process (Blackman et al., 2013; Cawsey et al., 2016). If change initiators and stakeholders feel that augmenting the status quo is unnecessary, resistance may occur and the change effort may be thwarted (Cawsey et al, 2016).

Unsuccessful organizational change efforts have been correlated with organizational ill preparedness including failure to address resistance to change (Self & Schraeder, 2009; Weiner, Amick, & Lee, 2008). Resistance can occur as a result of a disequilibrium within the preparation, execution or acceptance of an organizational change effort (Blackman et al., 2013). Cawsey et al. (2016) explain that organizational readiness for change is determined by a number of factors which include previous change experiences, the support and credibility of leaders within the organization, the flexibility, adaptability, readiness, openness and commitment of the organization to the change process and the perceived rewards for change. These factors may be exerting influence within Organization X.

By utilizing a readiness-for-change assessment tool, leaders can assess an organization's readiness for change (Cawsey et al., 2016). There are a number of readiness assessments available that can collect both qualitative and quantitative data from employees on their cognitive and emotional readiness to accept organizational change (Holt, Armenakis, Field & Harris, 2007). Three tools will be discussed, as it relates to this POP. First, the Organizational Readiness to Change Assessment instrument (ORCA) is a scale designed to assess organizational readiness prior to the implementation of evidence-based practice within a clinical setting (Helfrich, Li, Sharp, & Sales, 2009). Since this OIP proposal is suggesting to reintroduce Rapp & Goscha's (2012) SBCM Service Delivery Model as an initial change initiative, utilizing the ORCA would be advantageous as a readiness assessment tool to evaluate the organizational climate prior to a change initiative. However, this tool lacks validity thus continued research is required to improve the reliability among the measures of evidence (Helfrich, Li, Sharp, & Sales, 2009).

Second, the Organizational Capacity for Change (OCC) construct is another organizational readiness assessment tool that evaluates an organization's receptivity for change by assessing leader and organizational capacity (Judge & Douglas, 2009). This tool evaluates organizational openness for change amongst the change drivers. This tool could help evaluate the receptivity of the internal stakeholders to embark on a change initiative. Although the tool does evaluate organizational change capacity along eight defined, reliable, and valid dimensions, the tool has limitations. The OCC fails to account for how the degree of the organizational change may be an influential factor (Judge & Douglas, 2009). Additionally, the OCC does not consider environmental influential factors, like those previously indicated within the PESTE analysis, which could impact on an organization's capacity for change (Judge & Douglas, 2009).

Service N is unique within Organization X as it is the sole program within the agency that offers support for persons with a dual diagnosis. Therefore, it would be advantageous to use a readiness assessment tool designed for use within the developmental sector to supplement other readiness assessment tools. Schalock & Verdugo (2012) have composed a leadership guide for use specifically with developmental organizations that addresses evaluation and support needs. These authors identify an Organizational Self Assessment tool, that evaluates the organizational culture and how agency personnel approach issues specific to services and supports for persons with developmental disabilities (Schalock & Verdugo, 2012). This assessment tool is the third suggested organizational readiness assessment tool for use within this OIP. This Organizational Self Assessment tool compares the organization's mental model along a continuum between defect considerations and social-ecological stability (Schalock & Verdugo, 2012). Mental models are important to consider, as employee thoughts and perspectives directly relate to the willingness to adopt evidence-based practices (Helfrinch et al., 2009). However, the Schalock & Verdugo (2012) readiness assessment tool is inherently biased, focusing solely on a first-person account of readiness within the organization. Additionally, this tool lacks validity and reliability and requires additional testing.

It is recommended that all three assessments be used to assess change readiness within Organization X. Each suggested tool assesses a different dimension of the change effort, including whether the organization is ready for and receptive to change, and highlights the unique nature of developmental services sector organizations. All three assessment tools would encourage a more holistic, comprehensive and accurate assessment of the organization, in light of the relaunch of the change initiative within Service N. Furthermore, the aforementioned readiness assessment tools would complement Cawsey et al.'s (2016) Change Path Model and

help assess for this change initiative. More specifically, within the Awakening stage (Cawsey et al., 2016), internal metrics, satisfaction surveys and tacit knowledge could help assess for change readiness. Data collected from the three recommended readiness assessments would then be shared with clinicians and senior leadership and transformational leadership efforts could then be used to promote a new organizational state and better desired outcomes (Cawsey et al., 2016).

Chapter One Conclusion

Chapter One introduced the POP which questioned what leadership theories and frameworks could address the resistance within Service N in adopting Rapp & Goscha's (2012) Strengths Based Case Management Service Delivery Model. This chapter provided an organizational history which described the mission, vision, and established leadership approaches within Organization X. This author's leadership position and statement was articulated. The gap between current and future organizational practices was established. Factors affecting the POP were explored and macro, meso and micro change drivers identified. The importance of assessing change readiness, though a compilation of three various assessment tools was suggested.

Chapter Two of this OIP will identify the pertinent leadership approaches to address the POP and outline a framework for leading the organizational change process. Ethical considerations and possible solutions to the POP will be explored.

CHAPTER TWO

PLANNING AND DEVELOPMENT

Chapter One of this OIP introduced Organization X and identified the following POP: what leadership theories and frameworks could address the resistance within Service N in adopting Rapp & Goscha's (2012) Strengths-based Case Management Service Delivery Model? Chapter Two will explore the leadership approaches to change and identify transformational leadership, Cawsey et al.'s (2016) Change Path Model and Kotter's (1996) Eight-stage Model as necessary for leading the change process. A critical organizational gap analysis utilizing Nadler & Tushman's (1980) Congruence Model will provide a lens through which to consider the change process. Four solutions to the POP will be presented and critiqued. Two solutions will be identified as most appropriate and will be discussed.

Leadership Approaches to Change

As previously mentioned, transformational leadership was identified as the most appropriate leadership approach to propel Organization X successfully through the change process. Transformational leadership is woven throughout the fabric of this OIP; this next section will focus on the influence of transformational leadership in understanding the POP and in leading the change process.

Transformational leadership can be considered a panacea to effective change management (Alqatawenh, 2018). The emphasis of transformational leadership rests with creating meaningful connections that raise motivation and commitment to organizational objectives (Faupeel & Süß, 2018; Northouse, 2019; Stone et al., 2004). The Program Manager within Organization X holds a middle-management position, serving as a catalyst for organizational change by empowering the clinicians to be change mobilizers within the

organization (Shanker & Sayeed, 2012). With limited scope and agency to implement direct organizational changes, middle managers do impact the organizational environment by balancing performance delivery, front-line experience, and the emotional wellbeing of the team (Huy, 2001; Nonaka, 1994). Considering the middle-management position, the importance of utilizing transformational leadership within Organization X is acknowledged.

Transformational leadership impacts the way leaders view, understand, define and frame organizational problems while influencing decision making and leader actions (Bigham & Reavis, 2001). In fact, transformational leadership helps to reframe organizational problems so challenges can be considered through different perspectives by questioning assumptions and encouraging innovative and creative problem solving (Bigham & Reavis, 2001). Therefore, transformational leadership is vital when considering the change initiative through Bolman & Deal's (2013) Four-Frame Model.

The four components of Bolman & Deal's (2013) Four-Frame Model include political, structural, human resource and symbolic frames. Briefly, within Bolman & Deal's (2013) Political Frame, the limits of authority, reality of scarce resources, and the necessity of teamwork, may be acknowledged as essential to mitigate power struggles and conflict (Banks-Brisson, 2010; Bigham & Reavis, 2001). Within Bolman & Deal's (2013) Structural Frame, transformational leadership can encourage innovative behavior and strengthen motivation to improve organizational outcomes by clarifying roles, goals and outcome expectations (Bigham & Reavis, 2001; Garcia-Morales, Llorens-Montes, & Verdu-Jover, 2008). Within the Human Resource Frame, transformational leadership could help create a caring and trusting work environment by showing genuine concern for others which positively impacts on motivation and performance (Bigham & Reavis, 2001; Bolman & Deal, 2013; Garcia-Morales et al., 2008).

Within the Symbolic Frame, transformational leaders could acknowledge the importance of symbols, faith, meaning and shared rules by acknowledging how choice of a career, like social work, could reflect cultural elements and one's life philosophy (Bigham & Reavis, 2001; Bolman & Deal, 2013). Therefore, when considering the POP through Bolman & Deal's (2013) Four-Frame Model, it becomes apparent how transformational leadership could be advantageous in traversing organizational change impacting behavior, motivation, and culture.

Additionally, within Rapp & Goscha's (2012) SBCM Service Delivery Model, transformational leadership is referenced as a way of providing direction to employees on how to deliver services. Specifically, Rapp & Goscha (2012) refer to a cluster of managerial strategies within the model that closely resemble transformational leadership tenets, which include the use of an inspiring vision, role modelling behavior emphasizing client-centered approaches, and an optimal program design providing a variety of direction-setting goals and objectives. As depicted in Figure 1.1, managerial strategies also align well with the four components of transformational leadership (Bass & Avolio, 1994; Rapp & Goscha, 2012). Therefore, it seems reasonable to consider how transformational leadership can be used to address the resistance within Service N, when considering the POP through Bolman & Deal's (2013) Four-Frame Model and Rapp & Goscha's (2012) SBCM Service Delivery Model.

Despite how well transformational leadership aligns with the theories and service delivery model presented within this OIP, it is important to critically analyze the application of transformational leadership as an approach to leading change. Three cautions concerning transformational leadership are identified. First, it is important to acknowledge the unidirectional influence of transformational leadership from leader to followers (Barnett & McCormick, 2003). This unidirectional influence does not allow for follower feedback and

collaboration about vision or values. Second, the embedded values and beliefs of the leader are directly communicated to the followers. These values and beliefs are aligned with a leader's morals and ethics. Although ethical implications will be discussed later in this chapter, it is important to highlight how ethics is an essential component of business, influencing leader choices and the creation of an ethical work environment (Banerji & Krishnan, 2000). Tucker & Russell (2004) warn that leaders in abusive systems can misuse power for personal benefit. Although the likelihood of this occurring with the Program Manager in Organization X does not exist, it is a caution to be wary of. The last cautionary note concerns how transformational leadership excludes direct community input to influence leader behaviors and decision making (Barnett & McCormick, 2003). Although it is assumed that an authentic and ethical transformational leader would consider the needs of the community in any organizational vision, it is not stated outright and thus, is a presumed consideration.

In spite of the aforementioned cautions when applying transformational leadership, this leadership approach remains the optimal choice in leading change. Transformational leadership provides new direction, new inspiration and new organizational behaviors, essential in organizational development and for approaching change within Organization X (Tucker & Russell, 2004). In the next section, frameworks for leading the change process will be explored.

Framework for Leading the Change Process

In seeking to address the POP, Cawsey et al.'s (2016) Change Path Model and Kotter's (1996) Eight-stage Model will be explored as the necessary frameworks to advance the change process. As previously indicated, transformational leadership was aligned with Bolman & Deal's (2013) Four-Frame Model and with Rapp & Goscha's (2012) SBCM Service Delivery Model. As Figure 2.1 depicts, transformational leadership is the common leadership

characteristic evident within Cawsey et al.’s (2016) Change Path Model, Kotter’s (1996) Eight-stage Model, and Bolman & Deal’s (2013) Four-Frame Model.

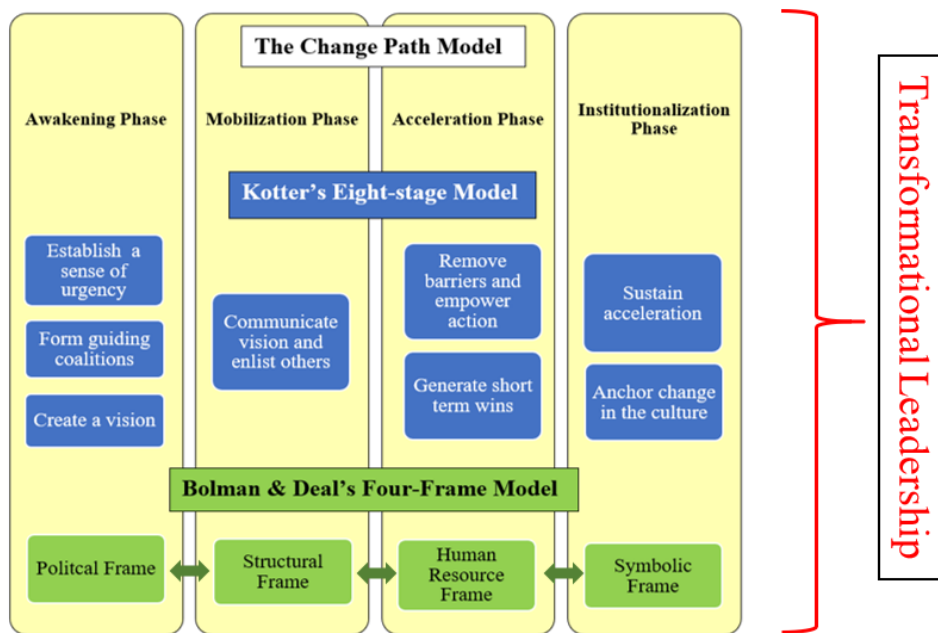


Figure 2.1. Transformational leadership evident within Cawsey et al.’s (2016) Change Path Model, Kotter’s (1996) Eight-stage Model, and Bolman & Deal’s (2013) Four-Frame Model. Adapted from “Unfreezing change as three steps: Rethinking Kurt Lewin’s legacy for change management”, by S. Cummings, T. Bridgman, & K. G. Brown, 2016, *Human Relations*, 69(1), p. 42.

Cawsey et al.’s (2016) Change Path Model. By utilizing a structured and planned approach through the Awakening, Mobilization, Acceleration and Institutionalization phases, Cawsey et al.’s (2016) Change Path Model allows for clear, incremental progression of the change process. Logical incrementalism may help create strategic change within Organization X. Within the initial phase, Awakening, collaborative engagement conversations with change agents and stakeholders could help identify the same gaps within Rapp & Goscha’s (2012) SBCM Service Delivery Model, lending support to a new strategic vision. Additionally, the Awakening phase aligns well with Bolman & Deal’s (2013) Political Frame. It is paramount that the need for change is clarified to change agents and stakeholders, to mitigate complacency and

responsibility diffusion which could impede organizational change efforts (Cawsey et al., 2016). Furthermore, transformational leadership could be helpful to the Program Manager and clinicians in eliciting information, suggestions and support for the vision and change process. It is through engagement and collaborative conversations within the Awakening phase where change agents' perspectives would be validated and help create a uniform, collaborative vision, supported by transformational leadership (Bass, Avolio, Jung, & Berson, 2003; Bolman & Deal, 2013, 2014). However, successful progression through the Awakening phase relies on the involved participants sharing a vision for change and establishing a mutual sense of urgency to address the issue. A failed consensus within this phase could halt the entire change effort.

Within the Mobilization phase, formal and informal structures and systems are identified as mechanisms to leverage and evolve the change process (Cawsey et al., 2016). Within this phase lies the need to communicate the vision for change to a wider audience, both internal and external to the organization. The Mobilization phase also aligns well with Bolman & Deal's (2013) Structural Frame. Acknowledging the current hierarchical decision-making process within Organization X, transformational leaders could help to advocate for changes which address team structure, decision-making responsibilities for file closures, and fidelity scoring processes. Transformational leadership could encourage the clinicians within Service N to act as messengers for organizational change efforts through mobilized, meaningful, positive, and future-oriented communication (Husain, 2013; Kotter, 1996).

The Acceleration phase involves empowering others into action by removing barriers, and once successful, celebrating the achievements (Cawsey et al., 2016). Furthermore, this phase aligns well with Bolman & Deal's (2013) Human Resource Frame. Bolman & Deal (2013) advocate that people are the greatest asset within any organization. The Human Resource

Frame is characterized by promoting egalitarianism, encouraging autonomy, knowledge acquisition, and meaningful work experiences (Bolman & Deal, 2013). These hallmark characteristics could help create motivation within a team to drive the change initiative, via effective communication and an action plan. This motivation, combined with transformational leadership, could also help reframe the change initiative and view change as a positive opportunity (Oreg & Berson, 2011).

The Institutionalization phase is the final stage of The Change Path Model (Cawsey et al., 2016). Continuous assessment and monitoring of the change initiative may indicate whether Organization X has adopted the new vision (Cawsey et al., 2016). The importance of collecting continuous data and analyzing client satisfaction surveys and intake/closure data within Organization X could help monitor the impact of the change initiative and areas for adjustment. This final phase also correlates well to Bolman & Deal's (2013) Symbolic Frame. With the emergence of a new, inclusive organizational culture, the mission and vision of the organization could be better aligned. Furthermore, with an improved organizational culture, the benefits could be wider reaching into the community. Transformational leadership would play an integral role in this phase, by renewing organizational commitment and by encouraging the employees to make Organization X's new vision a reality (Corrigan & Garman, 1999; Jaskyte, 2004).

Despite the merits of Cawsey et al.'s (2016) Change Path Model, there exist four significant demerits worth highlighting. First, the linear, sequential presentation of Cawsey et al.'s (2016) Change Path Model may suggest a simplification of an otherwise complex organizational change process (Mahato, 2015). Second, although this model addresses how and what to change, Cawsey et al. (2016) exclude other factors, besides motivation, as to why individuals should engage in organizational change (Mahato, 2015). Third, Cawsey et al.'s

(2016) Change Path Model is designed to address planned organizational change components. The model does not address how an organization should attend to unplanned change events (Mahato, 2015). Lastly, the model addresses fear and resistance to change, but does not address how to support employees who are experiencing or engaged in resistance or support employees who simply do not wish to change (Nodesson, Beleya, Raman, & Ramendran, 2012). In spite of these demerits, Cawsey et al.'s (2016) Change Path Model, is the recommended framework for leading the change process. The model is optimistic and hopeful of change efforts, supports communication and collaboration, addresses the notion of resistance and is considered the best framework to reintroduce Rapp & Goscha's (2012) SBCM Service Delivery Model, back into Service N.

Kotter's (1996) Eight-stage Model. Complementary to Cawsey et al.'s (2016) Change Path Model is Kotter's (1996) Eight-stage Model. Kotter (1996) pioneered his change management model by highlighting how organizations can be successfully transformed by following a linear sequence of eight steps. Kotter's (1996) eight steps include the need to communicate a sense of urgency, form a coalition, create a vision, communicate and enlist others, empower action and remove barriers, celebrate accomplishments, sustain acceleration and anchor the change within the organizational culture, to ensure adoption of the change initiative. Although Kotter's (1996) Eight-stage Model has been updated to support the needs of modern organizations (Kotter, 2014), for the purposes of this OIP, it was deemed necessary to build a solid foundation for organizational change first, by using Kotter's (1996) initial Eight-step model. A well-considered change process for Organization X demands a level of integration and sequencing of Kotter's (1996) eight steps before accelerating the change process (Applebaum, Habashy, Malo, & Shafiq, 2012; Kotter, 2014).

Kotter's (1996) Eight-stage Model is designed to be implemented into any existing structure. Both Cawsey et al. (2016) and Kotter (1996) address the importance of removing barriers contributing to resistance, which is central to this OIP. Fear of the unknown, decreased motivation, and disproportionate power relations associated with change initiatives contribute to behavioral, cognitive or affective resistance (Pieterse, Caniels, & Homan, 2012). Both Cawsey et al. (2016) and Kotter (1996) Models promote explicit, frequent and clear communication, highlighting milestone achievements. Since Cawsey et al.'s (2016) model focuses on the change, and Kotter's (1996) model highlights the impact of leaders, both models should work together to address the complexities that arise out of the POP. Moreover, both Cawsey et al.'s (2016) Change Path Model and Kotter's (1996) Eight-stage Model are clear, linear, sequential models which outline clear, detailed steps that can help traverse the uncertainty of change. Adherence to a process of organizational phases that build upon each other, helps ensure managers do not skip stages, contributing to failed change efforts (Applebaum, Habashy, Malo, & Shafiq, 2012; Kotter, 1995, 1996). This is important to consider within Organization X, to decrease the threat of organizational change fatigue with the reimplementation of the service delivery model within Service N (Bernerth, Walker, & Harris, 2011). Furthermore, the onus to communicate the vision of the organization is a collective responsibility of all staff, which could be achieved using transformational leadership within both models.

Despite the notoriety and the advantages concerning Kotter's (1996) Eight-stage Model, change management literature has highlighted disadvantages of the theory (Pollack & Pollack, 2015). Notable concerns with Kotter's (1996) Eight-stage Model include a lack of malleability with the linear model, an absence of a system for evaluating success, and criticism that change is a top-led leadership approach (Hughes, 2015; Pollack & Pollack, 2015). Furthermore, Kotter's

(1996) Eight-stage Model presumes all eight steps are to be followed for successful organizational transformation, yet the framework lacks detail to provide assistance with difficult change management scenarios (Applebaum, Habashy, Malo, & Shafiq, 2012; Cooper, Stanulis, Brondyk, Hamilton, & Macaluso, 2016).

Despite the aforementioned cautions concerning Kotter's (1996) Eight-stage Model, aligning Kotter's (1996) framework with Cawsey et al. (2016) Change Path Model may be considered a constructive approach to finding the best collaboration of change frameworks for an organization, based on the type of change being implemented (Applebaum, Habashy, Malo, & Shafiq, 2012). For Organization X, a clear, incremental, change plan which highlights urgent change and communication would be what is best for the agency. Therefore, Cawsey et al.'s (2016) Change Path Model and Kotter's (1996) Eight-stage Model are considered the necessary frameworks to advance the change process.

Critical Organizational Analysis

Bringing about organizational change could be a daunting task. For Organization X to be successful in its quest for an effective organizational change initiative, need areas within the organization should be identified through a gap analysis. There are a considerable number of tools suitable to conduct a gap analysis. The McKinsey 7S Framework (1980) and Burke-Litwin Causal Model (1992) are two examples of available, organizational gap analysis tools (Di Pofi, 2002; Ravanfar, 2015). However, for the purposes of this OIP, Nadler & Tushman's (1980) Congruence Model was assessed as the most appropriate gap analysis tool to address the resistance within Service N in adopting Rapp & Goscha's (2012) Strengths-based Case Management Service Delivery Model. Nadler & Tushman's (1980) Congruence Model is grounded in theory, derived from general systems theory (Nadler, 1981), which makes this

model more advantageous over the other two aforementioned tools. The Congruence Model examines both formal and informal elements within the gap analysis, considering the influence of people on organizational performance (Sato & Gilson, 2015). This is an important perspective emphasized throughout this OIP. Furthermore, Nadler & Tushman's (1980) Congruence Model specifically identifies resistance as a barrier to successful change management, highlighting the role of communication as a motivator of future action steps (Nadler, 1981). Within Chapter Three, a detailed communication plan is explored, with the intention of motivating others towards change.

As seen in Figure 2.2, the Congruence Model (1980) illustrates an integrative approach to managing organizational change, highlighting the interdependence of inputs, transformation, and outputs (Nadler, 1981; Nadler & Tushman, 1980).

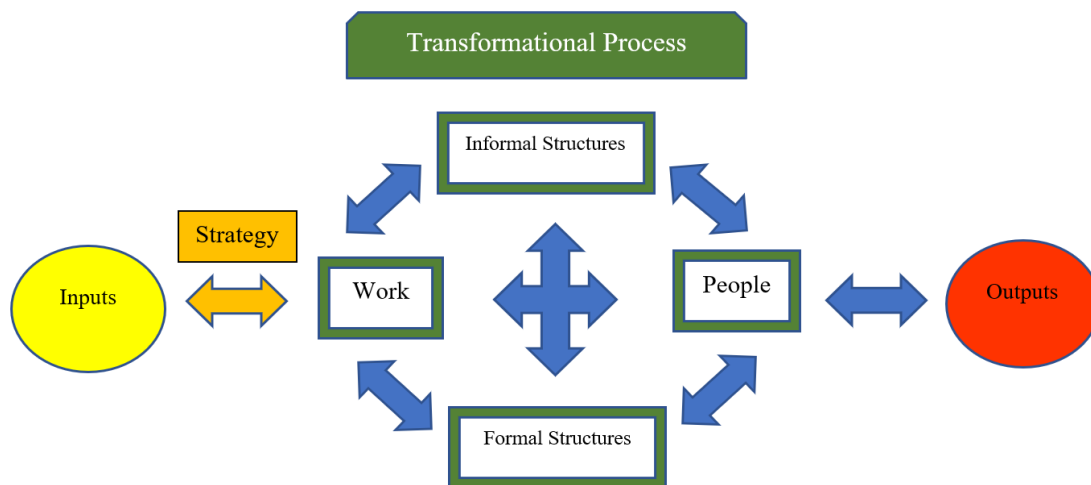


Figure 2.2. The Congruence Model. Adapted from “A model for diagnosing organizational behavior”, by D. A. Nadler & M. L. Tushman, 1980, *Organizational Dynamics*, 9(2), p. 47.

The Congruence Model (1980) considers dynamic and unique sets of people, processes and external environmental factors that impact interactions within an organization (Nadler, 1981).

This permits flexibility of the model within various organizational environments (Nadler, 1981).

Hence, utilizing a tool that easily enabled a gap analysis within a non-profit organization was advantageous within this OIP. The Congruence Model (1980) evaluates how well each part of the organization functions amongst other parts, known as congruency or fit (Nadler, 1981; Nadler & Tushman, 1980; Northouse, 2019). Although organizations strive for unattainable perfect congruence, the model suggests that steps towards this goal could be beneficial for any organization (Nadler, 1981). The Congruence Model (1980) and its components will be discussed in the following sections.

Inputs. The Congruence Model (Nadler & Tushman, 1980) identifies three sources of data, known as inputs, impacting the transformational process. First, the environment references all factors external to an organization that place demands and influence the current and future state (Nadler, 1980). Organization-specific environmental inputs will now be explored. For instance, within the metropolis, non-profit organizations compete for municipal funding envelopes which can affect Organization X's annualized municipal funding. Service N is the smallest, in-house program within Organization X, yet is responsible for all the case management needs for clients with a dual diagnosis. Furthermore, the clinicians within Service N are all registered social workers, each bound by a regulating body, an array of professional standards and code of ethics, explored later in this chapter. All staff within Organization X are unionized, which dictates workload, overtime restrictions and collective bargaining agreements. Legislation dictates the ethical and professional manner in which services must be delivered to clients. Additionally, Organization X is currently bound by a service agreement with a ministry, outlining service expectations and outcomes. The PESTE analysis explored within the previous chapter, provides additional external factors for consideration when addressing the POP. Each

of these environmental influences must be considered when contemplating an organizational change initiative.

The second input is resources; accessible organizational assets including employees, technology, capital, organizational culture and the perception of the organization within the community (Nadler, 1981; Nadler & Tushman, 1980). When considering resources, consideration for quality and flexibility is paramount (Nadler & Tushman, 1980). Within Organization X, each of the clinicians within Service N have employment longevity and Organization X does allow internal transfers of staff into different positions within different programs throughout the agency. Therefore, it is possible that the team of clinicians within Service N currently, will not be the same team following the change initiative, should internal transfers occur. This may affect team dynamics and degree of resistance experienced within Service N.

Rapp & Goscha's (2012) SBCM Service Delivery Model, requires completion of the Strengths Assessment and Personal Recovery Plans, as outlined in Appendix A and B. Currently, these documents are paper formatted tools and are not available in a web-based format. Having such tools available electronically on a company issued smart phone, tablet or laptop, could decrease employee workload pressures. However, a technological benefit for clinicians may serve as a barrier for clients. An individual on financial assistance may struggle to meet financial demands and be unable to budget for technological gadgetry or internet access. In addition, the ability and skill required to navigate advanced technology requires literacy skills and knowledge that some individuals with a dual diagnosis may struggle with.

Organization X holds the monopoly within the city on providing free, intensive case management services for persons with a dual diagnosis. Competition with similar non-profit

organizations is small. The Organization prides itself on providing excellent client-centered care. The morale within the organization is impacted by workplace stressors and the challenges working with vulnerable populations. How an organization operates is influenced by past organizational history (Nadler & Tushman, 1980). Over the last decade, the organization has seen tremendous growth in client and employee capacity and significant turnover in senior management personnel and the Executive Director. The strategic direction of the organization has been significantly influenced by the Board of Directors. Community partnerships and other internal programs have grown, and demand for services has drastically increased. The influx of clients awaiting services has created a wait list. When considered all together, there are numerous resources exerting influence on Organization X and organizational change efforts.

The last input is strategy. Strategy is one of the most important single inputs for an organization and will determine the nature of the work for the organization (Nadler & Tushman, 1980). Strategy matches an organization's resources with the environment, commonly articulated within the organization's mission statement (Nadler, 1981). As explored within Chapter One, Organization X aspires to deliver ideal evidence-based, holistic, intensive case management supports to address mental health needs. The strategic decision to adopt Rapp & Goscha's (2012) SBCM Service Delivery Model highlighted the organization's intention of achieving this mission through collaborative partnerships with clinicians and community resources.

In summary, the interaction of the environment, resources, and history creates a dynamic interaction when combined with strategy to create the transformational process (Nadler & Tushman, 1980). The transformational process is created through the interaction of work, people, informal and formal organization components (Nadler & Tushman, 1980). "The basic

hypothesis of the model is that organizations will be most effective when their major components are congruent with each other” (Nadler, 1981, p. 194). If there is poor fit, organizational problems arise. Below is an exploration of the four components within the transformational process.

Transformational process. Work, people, formal and informal organizational components work together to form the transformational process within Nadler & Tushman’s (1980) Congruence Model. The work component describes the basic and inherent activity that the organization and employees engage in, to further the organization’s strategy (Nadler, 1981). A thorough analysis must commence with an understanding of the nature of the tasks to be performed, workflow patterns, knowledge requirements, rewards and stressors (Nadler, 1981). As previously mentioned, Organization X provides intensive case management services for persons with mental health challenges. Service N provides specific mental health support for persons with a dual diagnosis. The nature of mental illness is unpredictable which creates unpredictable outcomes and working environments for the clinicians. Having an intellectual disability, compounded with a mental illness, may be an additional challenge for service delivery. All clinicians within the organization must deliver strengths-based, intensive case management services which requires the use of the Strengths Assessment and Personal Recovery Plans. However, there exists a challenge in using these tools with clients who have a dual diagnosis. Outcome fidelity measures and goal attainment scores within Service N are low. The current morale is low within the team, and resistance towards using the model is high.

The second component in the model consists of the people who perform the organizational tasks. Thus, it is important to identify the salient characteristics of the people who perform the core work within the organization (Nadler, 1981). The clinicians within Service N

have expert knowledge and skills to work with individuals with a developmental disability and mental illness. As registered social workers, each clinician holds a social justice perspective, evident in their beliefs and actions. Each clinician wants their clients to succeed and attain their goals. Furthermore, it is an organization-wide expectation, that all employees are ambassadors of the organization, conducting themselves in a morally and ethically sound manner, and contributing to the community by challenging mental illness stigma, as outlined in the Code of Conduct within Organization X.

The third component within the model consists of the formal organizational arrangement, including structures, processes, methods, and procedures which dictate how employees perform organizational duties to achieve strategic objectives (Nadler & Tushman, 1980). As previously discussed, Organization X is divided into different programs, based on client cohort needs. The expectation is that all clients within the organization receive the same type of strengths-based, intensive case management service as outlined by Rapp & Goscha's (2012) SBCM Service Delivery Model. Furthermore, the expectation is that all clients are evaluated on goal attainment using identical fidelity score measures, regardless of mental health diagnosis or intellectual capacity. However, cognitive challenges can impede a client's ability to relay need or recall or historical information. Nonetheless, each clinician is to perform their case management functions, utilizing naturally occurring resources as supports to complete the required assessments and plans for evaluation.

The final component of the model consists of the informal organization. These informal components are most commonly implicit, unwritten guidelines that help form the culture of the organization (Nadler, 1981). For example, behavior and communication of the clinicians are important features of the informal organization which can influence relationships within Service

N and with others throughout the organization about persons with a dual diagnosis. If behavior and communication is positive and supports the service delivery model, these informal organizational components could support formal organizational structures. For instance, when Service N clinicians complete a Strengths Assessment or Personal Recovery Plan for a client, this behavior could influence other staff to implement this practice, inadvertently communicating that fidelity to the model may not need to be followed exactly to complete the paperwork. Furthermore, within the Awakening phase of the Change Path Model (Cawsey et al., 2016), a gap analysis may highlight the impact of leader behaviors on the organizational culture. Addressing the impact of organizational change on organizational culture is evident within Kotter's (1996) Eight-stage Model, further illustrating the iterative nature of the theories within this OIP.

In summary, organizations can be thought of as a set of components; work, people, formal and informal arrangements. To reiterate, it is the nature of the relationship or fit among the components that is most important to consider in an organizational change effort. Behavioral, cognitive and affective resistance indicates a poor fit among the components.

Outputs. The ultimate purpose of any organization is to produce an output (Nadler, 1981). Outputs can be considered on three different levels; system, organization and individual. At a system level, the needs of persons with mental illness are being addressed. At an organizational level, clinicians throughout the organization are positively supporting client goal attainment and community partnerships as evidenced in data. However, Service N, in comparison to other programs within the organization, is performing sub-optimally. At an individual level, Service N clinicians are dissatisfied with client outcomes on fidelity measures, despite effort, dedication and work performance. Following the successful implementation of

the organizational change initiative, positive individual outputs would include less resistance, collaborative decision making through transformational leadership approaches, case management delivery based on differentiated capacity building and increased client goal attainment.

In summary, Nadler & Tushman's (1980) Congruence Model, as a gap analysis tool, illustrated the interdependence of inputs, transformation and outputs addressing the POP. In the following section, four possible solutions to address resistance within Service N in adopting Rapp & Goscha's (2012) SBCM Service Delivery Model, will be explored.

Possible Solutions to Address the POP

This section describes four possible solutions to address the POP. Three alternatives, in addition to the status quo are proposed; I-START Program, involvement of family members and caregivers, and adopting differentiated capacity building. The necessary resources including time, human, fiscal, and technology, potential trade-offs and consequences of each solution are explored and summarized in Table 2.1. Based on this analysis, the best possible solution that combines two possibilities will be described.

Solution 1: Status quo. Maintaining the status quo would see the delivery of Rapp & Goscha's (2012) SBCM Service Delivery Model remain the same. Although this model has proven successful in supporting persons with psychiatric illness (Burns & Rapp, 2001; Ibrahim, Michail, & Gallagher, 2014; Rapp, 2014; Rapp & Goscha, 2012), this specific service delivery model has not been researched with clients who have a dual diagnosis. Studies have found that case management can support individuals with developmental disabilities if their special needs are addressed (Criscione, Walsh, & Kastner, 1995; Kastner, Walsh, & Criscione, 1997; Long, Coughlin, & Kendal, 2002; Walker, 2014). Professionals who deliver case management support to individuals with developmental disabilities must carefully consider the development of clear,

communicated processes (Weise, Fisher, Whittle, & Trollor, 2018). However, maintaining the status quo does not account for the specialized processes required for persons with a dual diagnosis. If the status quo was maintained, low fidelity measures on the Strengths Assessment and Personal Recovery Plans could continue and clients may not achieve their goals. No additional resources are required to maintain the status quo as there would be no changes in service delivery.

Maintaining the status quo could also perpetuate continued cognitive, behavioral and affective resistance within the Service N clinicians. This resistance could negatively affect the team's morale and overall organizational culture. Furthermore, by maintaining the status quo, paper and pencil data collection methods would continue to affect clinician administrative duties and perpetuate cost ineffectiveness. Most importantly, if the status quo is maintained, the clients within Service N would continue to receive services that overlook their cognitive learning needs. Eventually, this oversight may question the mission and vision of Organization X and query whether the organization is providing ideal evidence-based practices for those with intellectual and mental health challenges.

Solution 2: I-START Program. The second solution involves a radical departure from current case management practices, as outlined within Rapp & Goscha's (2012) SBCM Service Delivery Model. This proposed solution involves replacing the current service delivery model and adopting the I-START Program for use specifically with clients with a dual diagnosis within Service N.

Briefly, the I-START Program, an acronym for Iowa Systemic, Therapeutic, Assessment, Resources & Treatment program, is an evidence-informed, community based, crisis prevention and intervention model which utilizes a variety of therapeutic approaches to support persons with

intellectual disabilities and mental illness (Beasley, Kalb, & Klein, 2018; Kalb, Beasley, Klein, Hinton, & Charlot, 2016). The program's goal is to reduce costly and restrictive inpatient hospitalization of persons with intellectual disabilities and mental illness by supporting and accessing high quality community supports through a team of specialized professionals with an expertise in dual diagnosis (Beasley, Kalb, & Klein, 2018; Kalb, Beasley, Klein, Hinton, & Charlot, 2016). It is beyond the scope of this OIP to fulsomely explore the intricacies of the I-START Program, yet this option should be considered as a potential solution to the POP.

In 2015, prior to the implementation of Rapp & Goscha's (2012) SBCM Service Delivery Model, the current clinicians within Service N attended the I-START training and received certification. Adopting the I-START Program would support the unique needs of clients with a dual diagnosis, support our service agreements with agencies and the ministry, and help fulfill our mission and vision of providing ideal evidence-based mental health supports. However, implementing the I-START Program within Service N would require endorsement and support within the Senior Management Team and with the Executive Director and Board of Directors, since the I-START Program is a 24-hour service, employing crisis management and behavioral specialists (Beasley, Kalb, & Klein, 2018; Kalb, Beasley, Klein, Hinton, & Charlot, 2016). These requirements would necessitate an extensive organizational change within Organization X, as it is not a 24-hour, crisis service. Implementing the I-START Program would also require a significant financial investment by the ministry and municipality and would require a significant time and financial commitment for annual recertification purposes. Moreover, the data management team within Organization X would be required to redesign data collection metrics and a statistical analysis program different from all other programs, which would be a large, labour-intensive, organizational undertaking. The Program Manager would need to collaborate

with the clinicians, senior leadership and external stakeholders for a strategic implementation plan during the transition period from one case management service delivery model to the other, without service disruption for clients.

There may be unforeseen consequences of such a radical proposed solution. For example, the I-START Program may not be successful within Canada despite thorough planning and execution. The I-START Program may not reduce the inpatient hospitalizations. The I-START Program may increase resistance within the organization based on the 24-hour working requirement. Despite these possible outcomes and the enormity of this idea, it is important to consider program requirements to support persons with a dual diagnosis. Perhaps detailed exploration of the I-START Program within Canada could be the focus of a future OIP.

Solution 3: Involvement of family members and caregivers. The third solution explores partnering with family members and caregivers within Rapp & Goscha's (2012) SBCM Service Delivery Model by involving them in service delivery. Within Rapp & Goscha's (2012) SBCM Service Delivery Model, there is an expectation to engage and build relationships with community resources. This proposed solution recommends the expansion of the client-clinician partnership to include family members and caregivers (Rapp & Goscha, 2012). The intensity and types of supports needed by persons with intellectual disabilities and mental health challenges vary, thus it is important to learn what supports a particular person requires to enhance functioning (Thompson et al., 2009). Most often family members and caregivers are the primary support systems for a person with an intellectual disability and co-occurring mental health challenge (Beasley, Kalb & Klein, 2018). Clients will tend to disclose mental health struggles to those with whom they are bonded (Weise, Fisher, Whittle, & Trollor, 2018). Furthermore, family members and caregivers are likely to have vital information about the

person's mental health or historical data that would be advantageous to clinicians and necessary to score on assessment tools (Weise, Fisher, Whittle, & Trollor, 2018).

The more information that is shared amongst clinicians and supports, helps to create a more comprehensive picture of a person's mental health and status over time (Weise, Fisher, Whittle, & Trollor, 2018). The involvement of family members and caregivers in care planning and the therapeutic process is well documented and acknowledged as vital within mental health literature (Alborz, McNally, & Glendinning, 2005; Cleary, Freeman, & Walter, 2006; Cree et al., 2015; Walker & Dewar, 2001; Whittle, Fisher, Reppermund, & Trollor, 2018). Therefore, when a person with a dual diagnosis is unable to provide specific information on the Strengths Assessment and Personal Recovery Plan, it appears reasonable to collaborate with other parties who can recall vital, care planning information. This proposed solution invites family members and caregivers to participate in conversations related to assessment and planning within Rapp & Goscha's (2012) SBCM Service Delivery Model and permits clinicians to incorporate this information into the Strengths Assessment and Personal Recovery Plan, which are then scored. This proposed solution would require calculating fidelity scoring by including the secondary information gathered from family and caregivers as primary information. Permitting secondary information into the fidelity score card is within my scope and agency as Program Manager to support and implement.

There are opportunities inherent within Rapp & Goscha's (2012) SBCM Service Delivery Model to collaborate with family members and caregivers. For example, within the Strengths Assessment, as seen in Appendix A, higher fidelity scores are attributed to thorough answers that detail client language, strengths, goals, and past utilized resources. A variety of questions on the Strengths Assessment have been provided within Appendix C. Recalling this information may

be difficult for clients with intellectual disabilities. When family members and caregivers contribute this information, not only is the assessment more thorough for the clinician, but fidelity scores can be tabulated as higher, circumventing premature file closure due to low scores. Furthermore, consider the Personal Recovery Plan in Appendix B. This document requires tracking of dates, with progressive goal acquisition steps identified by designated completion dates. An example of a completed Personal Recovery Plan is available within Appendix D. The ability to break tasks into smaller activities involves planning and executive functioning, which may pose challenging for an individual with an intellectual impairment or receptive and expressive communication challenges, and severe and persistent mental illness. Including family members and caregivers in the completion of the Strengths Assessment and Personal Recovery Plan could be instrumental in identifying goals, accurate past and present information and provide cueing along the recovery path.

Involvement of family members and caregivers must be carefully traversed by clinicians. The clinicians would need to ensure that goals and the recovery plan are reflective of the client's intentions and not those of the family members and caregivers. At times, client and family member goals may be incongruent (Walker & Dewar, 2001). Therefore, it is possible that clinicians may need to play a dual role; mediator and case manager, to ensure goals are client directed. The clinicians have been trained in motivational interviewing and coaching which are advantageous in such situations. The clients would need to consent to have family members and caregivers involved with assessments and planning. Obtaining the necessary consents prior to meetings could require superior time management skills and organization by the clinicians. Despite these challenges, collaborating with family members and caregivers on these tools may

provide more accurate information and mitigate literacy and recollection problems that clients could encounter.

This proposed solution would require a significant time investment from the clinicians. The clinicians would be required to interview additional parties to complete the tools, and would also need to invest more time in arranging for and executing collaborative meetings. Travelling to and from additional meeting destinations would impact the travel expense budget within Service N. Although it would be advantageous to utilize virtual meeting platforms to conduct collaborations, not all family members or caregivers are equipped with such technological advancements, further necessitating face-to-face meetings and additional workload requirements for the clinicians.

Solution 4: Differentiated capacity building. In the absence of field related literature on Rapp & Goscha's (2012) SBCM Service Delivery Model with clients with a dual diagnosis, an innovative idea from the field of education will be explored as the fourth solution to address the POP. Differentiated capacity building is a term that was specifically created for this OIP. Differentiated capacity building is described as the development of resources, effective practices and tools, tailored to the learning needs and capabilities of the clients within Service N.

Within this OIP context, to differentiate means to be organized, flexible, and adaptive as a way to proactively plan and deliver learning material, addressing individual learning needs (Tomlinson, 1999). There exists a plethora of work that articulates how differentiation has been extensively used within educational settings to address the needs of students with varied learning styles, abilities, readiness, experiences and interests (Gregory, 2003; Tomlinson, 1999, 2003; Tomlinson & McTighe, 2006). Although Organization X is not a designated educational setting, with a focus on learning new skills, strengths philosophy, assessments, planning, goal setting and

one-one-one exchanges, a convincing argument can be made that the environment in which Rapp & Goscha's (2012) SBCM model is delivered to clients can resemble an educational setting. In fact, each clinician is tasked to differentiate interventions and progression through service delivery in response to individual, client needs, like a teacher within a classroom.

Within the context of this OIP, capacity building is defined as the evolution of an organization's practices to best address the needs of the client (Fullan, 2016). Capacity building includes knowledge, skill acquisition, competencies, improved resources and commitment (Fullan, 2016). By combining differentiation with capacity building, the term differentiated capacity building creates the innovative fourth solution to the POP.

Within educational settings, knowledge of multiple intelligences and learning styles are commonplace (Denig, 2004). Having this knowledge could be beneficial for Organization X in adapting the Strengths Assessment and Personal Recovery Plans for clients with a dual diagnosis. Gardner (1999) identifies eight distinct intelligences; linguistic, logical-mathematical, spatial, kinesthetic, musical, interpersonal, intrapersonal, and naturalistic. These eight intelligences can be explained as the biopsychological potential of a person to process information, learn, and problem solve (Denig, 2004; Gardner, 1999). Conversely, Dunn & Dunn (1993, 1999) explained learning styles as 21 unique elements, further classified into environment, emotional, sociological, physiological and psychological variables, that influence the way a person concentrates, processes, internalizes, and remembers information. Furthermore, every person has a primary and secondary learning style (Dunn & Dunn, 1993, 1999).

Both Gardner (1999) and Dunn & Dunn (1993, 1999) challenge educators to amend the manner in which information is taught. Multiple intelligences addresses changing what is taught

(Gardner, 1999), whereas learning styles address how information is taught (Denig, 2004; Dunn & Dunn, 1993, 1999). In differentiated capacity building, both the product and the process are addressed, therefore multiple intelligences and learning styles are integrated as a solution to the POP.

Schools frequently modify programs to support student learning and development (Gilmore, Campbell, & Shochet, 2016). For example, the Aussie Optimism Resilience Skills Program in Australia, is one such evidence-based school program that was adapted to address the mental health needs of students with intellectual disabilities (Gilmore, Campbell, & Shochet, 2016). The modified program included shorter sessions, slower learning pace, repetition, demonstrations, role plays, individual or group work exercises and specially developed student workbooks and resource manual (Gilmore, Campbell, & Shochet, 2016). This program aligns well with the proposed solution; differentiated capacity building within Rapp & Goscha's (2012) SBCM Service Delivery Model. Appendix E explores various methods in which multiple intelligences and learning styles could be adapted within the Strengths Assessment and Personal Recovery Plan.

Implementing differentiated capacity building as a solution to the POP would require significant time, budgetary and human resource investment. The clinicians would need to learn how to adapt the material within Rapp & Goscha's (2012) SBCM Service Delivery Model, and be given time to prepare the material. This could result in increased administrative duties for the clinicians and resources to create visual or auditory adaptations. Conversely, differentiated capacity building would allow the clinicians autonomy to deliver material in an individualized manner, drawing upon their expert skills and knowledge base. Differentiated capacity building also upholds client involvement in their recovery path. Since differentiated capacity building

permits innovative and flexible delivery methods, clinicians could use a variety of means to obtain information required to complete the tools. For example, clients could draw answers instead of using words to communicate or use pictures or photographs to help with recollection of information, as explored within Appendix E. Just like a teacher in a school setting, the clinicians would be central to the implementation of successful differentiated learning activities (de Jager, 2013).

In summary, four solutions were presented to address the POP; status quo, I-START Program, involvement of families and caregivers, and differentiated capacity building. Table 2.1 summarizes the plethora of information presented. The two best solutions that address the POP are the involvement of families and caregivers and differentiated capacity building. Together, both solutions address a different component of the problem; that clients may not be able to recall information based on their intellectual capacity, and the need to consider multiple intelligences and learning styles in client-centered service delivery. In the next section, potential trade-offs and consequences of each solution will be explored and the best possible solution will be presented.

Table 2.1

Comparison of four solutions to the Problem of Practice

Proposed Solution	Necessary changes	Resource Needs	Advantages of Proposed Solution	Disadvantages of Proposed Solution
Status Quo	No changes necessary	<ul style="list-style-type: none"> - No change in time, human need or budget resources - Increased clinician effort required to raise fidelity scores - Technologically challenged 	<ul style="list-style-type: none"> - Mitigate organizational change fatigue - Resistance may decrease 	<ul style="list-style-type: none"> - Resistance may increase - Risk of losing funding - Client needs not being met
I-START Program	Replace current intensive case management service with the I-START Program	<ul style="list-style-type: none"> - Significant investment in time required for training and recertification, in human need for learning, in financial investment, technology upgrades and data collection measures 	<ul style="list-style-type: none"> - Clinicians certified in I-START in 2015 - Program specifically designed to provide support for clients with dual diagnosis - Evidence-informed practice 	<ul style="list-style-type: none"> - Requires replacement of the current service delivery model - Not yet researched within Canada. - Labor intensive, requires and its own organizational improvement implementation plan
Involvement with family members and caregivers	Invite collaboration within current service delivery model	<ul style="list-style-type: none"> - Significant time commitment, time management requirements, financial expense - Commitment of all parties required - Technology challenges 	<ul style="list-style-type: none"> - Invite collaboration within current service delivery model - Detailed assessments and recovery plans with accurate historical information accounts - Could benefit other clients with disabilities 	<ul style="list-style-type: none"> - Calculate fidelity scores from secondary source as primary information - Challenges could arise regarding consents, participation, identification of priority goals
Differentiated capacity building	Implement differentiated capacity building within the current service delivery model	<ul style="list-style-type: none"> - Significant time commitment to create individualized material - Significant human need and financial resources required - Seek alignment of expertise and technology with service delivery 	<ul style="list-style-type: none"> - Using expertise of clinicians - Client-centered - Utilizes in-house resources through distributed leadership - Could benefit other clients with disabilities 	<ul style="list-style-type: none"> - Time consuming for clinicians - Adjustment to caseload size necessary to account for time spent on creating individual materials

Trade-offs, benefits and consequences. In this section, the various trade-offs, benefits and consequences of the four solutions will be discussed. Similarities between each solution are described. While maintaining the status quo would require the least amount of additional resource investment, the outcome could perpetuate behavioral, affective and cognitive resistance within Service N. Additionally, this option would not support clients with a dual diagnosis, thus questioning the integrity of the Organization's purpose, mission and values. For these reasons, the status quo, would not be the best solution to address the POP.

Conversely, the I-START Program solution requires the most resources since it would be a drastic organizational change proposal significantly different from the status quo. Although in 2015, the clinicians were supported by the Senior Management Team to attend, train and gain certification as I-START Program clinicians, implementing this program would be a significant undertaking, requiring a program overhaul, a substantial budgetary investment requiring unanimous ministry and stakeholder support. This solution would change the organization into a 24-hour crisis service provider. To invest these resources into the smallest program within the non-profit organization, at a time when questionable funding structures are impactful, may prove difficult for advocacy purposes despite the fact that the I-START Program was designed for use with persons with dual diagnosis. Implementing another program change within Service N could also exacerbate the risk of organizational change fatigue, positively associated with employee exhaustion and negatively related to organizational commitment (Bernerth, Walker, & Harris, 2011). For these reasons, the I-START Program would not be endorsed as the proposed solution to address the POP.

Identified solutions. Upon analysis, developing a solution that addresses the needs of both the client and the clinician, is achievable through the involvement of family members and caregivers and utilizing differentiated capacity building within Rapp & Goscha's (2012) SBCM Service Delivery Model. Involvement of family members and caregivers helps gain access to information that a client with an intellectual disability may not have. Differentiated capacity building amends the product and process so clients are able to actively participate in service delivery, based on multiple intelligences and learning styles. Transformational leadership would also involve family members and caregivers in service delivery to implement differentiated capacity building.

Human resource needs are a key consideration and appear within each of the four solutions, highlighting necessary clinician time commitment and investment for successful solution implementation. Although involvement of family members and caregivers and differentiated capacity building would require the most significant human resource investment, the benefit to the clients would be most impactful. Furthermore, the time management challenge could be mitigated through delegation, leveraging technology, or case load redistribution. Organization X delivers client-centered, strengths-based care. Involving a person's support network may help the clinician gain a more comprehensive picture of a person's mental health and intellectual capacity (Weise, Fisher, Whittle, & Trollor, 2018). With such understanding, a clinician could then problem-solve to modify instructions and tools (Broderick, Mehta-Parekh, & Reid, 2005) to deliver the organization's intensive case management service.

There is no precedent for such modifications to Rapp & Goscha's (2012) SBCM Service Delivery Model. Therefore, collaborators and stakeholders have the freedom to be innovative in addressing client mental health and intellectual disability needs. A descriptive, change

implementation plan, in the form of a Plan-do-study-act (PDSA) Cycle (Cleary, 1995; Gupta, 2006; Taylor et al., 2014) will structure an iterative change process; the focus of Chapter 3.

Ethics

The importance of ethics within organizational management impacts individuals, groups, organizations and society simultaneously and therefore, can not be understated (Burnes, 2009). Northouse (2019) defines ethics as “the kinds of values and morals an individual or a society finds desirable or appropriate” (p. 336). As it relates to this OIP, leadership ethics and organizational change issues are interconnected. In the following section, ethical considerations as they relate to inclusion, leadership approaches to change and establishing relationships are explored.

The cornerstone of Rapp & Goscha’s (2012) SBCM Service Delivery Model is the belief that every person has the right to determine individual goals and the direction of their recovery from psychiatric illness. Historically, persons with intellectual disabilities have endured a disturbing history of harmful and exclusionary practices, often associated with involuntary research (Freedman, 2001; McDonald, Conroy, & Olick, 2016). In an effort to uphold equality and human rights, it is ethically necessary to include persons with intellectual disabilities in the decision-making processes which affect them (Brooker et al., 2014; Feldman, Bosett, Collet, & Burnham-Riosa, 2013; Iacono & Carling-Jenkins, 2012; McDonald, Conroy, & Olick, 2016). When persons with intellectual disabilities are included in personal planning and research, they feel valued, included, experience equality and demonstrate learning capabilities and strengths (McDonald, Conroy, & Olick, 2016). This logic could also apply when persons with a dual diagnosis are active participants in their intensive case management service delivery. Therefore,

client consent and involvement are inherent to planning and goal achievement (Burns & Rapp, 2001; Rapp, 2014; Rapp & Goscha, 2012).

Clinicians, program managers and senior leadership personnel within Organization X are accountable in establishing an ethical environment through ethical leadership (Cherkowski, Walker, & Kutsyuruba, 2015). Ethical leadership is evident with successful organizations since effective leaders are models of ethical and moral leadership (Mathooko, 2013). In fact, organizational ethics “connotes an organizational code conveying moral integrity and consistent values in service to the public” (Banerji & Krishnan, 2000, p. 405). Ethical leaders share ethics and values with followers, inspire others to implement a vision, and aspire to social justice through community involvement (Zhu, Zheng, Riggio, & Zhang, 2015). Thus, based on the tenets of ethical leadership, transformational leadership could be considered ethical-related leadership.

As previously discussed within Chapter One, transformational leadership was identified as the optimal leadership approaches to lead the change process. Transformational leadership involves elevating the ethical aspirations of the leader and followers (Banerji & Krishnan, 2000; Dion, 2012; Geer, Maher, & Cole, 2008). Transformational leadership also focuses on the interdependent relationship between leaders and followers within a mutually supportive, ethical relationship (Cherkowski, Walker, & Kutsyuruba, 2015). For ethical leadership to be effective, it should include both technical competencies to affect motivation and moral capacity to affect ethical aspiration, which are also predictors of non-profit, organizational accountability (Banerji & Krishnan, 2000; Zhu, Zheng, Riggio, & Zhang, 2015). Therefore, the ethical components of transformational leadership are important considerations within this OIP.

As mentioned previously, each clinician within Service N, is a registered social worker. Therefore, each clinician is expected to uphold the core values of the profession and minimum standards of professional practice and conduct through ethical leadership (Canadian Association of Social Workers, 2005). The core values within social work include respect, dignity, integrity, confidentiality and competence (Canadian Association of Social Workers Code of Ethics, 2005). Social workers also have an ethical responsibility which includes maintaining the best interests of the client as a priority, collaborate with other professionals, promote autonomy of the client, and renegotiate or terminate professional services when the services are no longer required (Canadian Association of Social Workers Code of Ethics, 2005). As employees within Organization X, the clinicians must demonstrate the agency's vision and core values in their interactions with clients. Therefore, it is also an expectation of the organization that clinicians employ consistent ethical service delivery standards.

In summary, ethics play an integral role in the leadership process (Northouse, 2019). Ethical expectations are outlined within the mission and vision of the organization, the service delivery model, and the social worker professional practice standards. Therefore, by virtue of leadership influence, the leaders within Organization X have an ethical responsibility that affects others (Northouse, 2019). In turn, ethical leadership also helps to establish transformational leadership and inclusionary practices within the organization. Consequently, leadership ethics and organizational change are symbiotic.

Chapter Two Conclusion

In conclusion, Chapter Two explored how transformational leadership was identified as the preferred leadership approach to lead the change initiative within Organization X. The Change Path Model (Cawsey et al., 2016) and Kotter's (1996) Eight-stage Model were explored

as the necessary frameworks for leading the change process, which also aligned well with Bolman & Deal's (2013) Four-Frame Model. Nadler & Tushman's (1980) Congruence Model was identified as the most suitable gap analysis tool for consideration within the change process. A variety of inputs influence the transformational process and outputs within the tool. Four possible solutions to address the POP were presented; status quo, I-START Program, partnerships with family members and caregivers and adopting differentiated instruction. The proposed solution involves an innovative combination of family and caregiver involvement and differentiated capacity building. Ethical considerations were explored in relation to inclusion, leadership and organization change influences.

Chapter Three of this OIP will explore a change implementation plan. This will outline the strategy for change, change process monitoring and evaluation approaches and communication plan for the proposed solution. Next steps and future considerations will be explored.

CHAPTER THREE

IMPLEMENTATION, EVALUATION, AND COMMUNICATION

The purpose of this OIP is to outline which leadership theories and frameworks could address the resistance within Service N in adopting Rapp & Goscha's (2012) SBCM Service Delivery Model. The final chapter of this OIP will outline a change implementation plan, detailing the strategy for managing the proposed change. This chapter will also explore a Plan, Do, Study, Act (PDSA) Model, specifying tools and measures to assess the change. The importance of monitoring and evaluation will be explored. A detailed communication plan and strategy will highlight the approach for building the change process. Next steps will be articulated and future considerations presented.

Change Implementation Plan

The following change implementation plan outlines a year-long strategy and beyond for organizational change to address the POP. As indicated in Chapter Two, two proposed solutions were presented, which addressed the resistance within Service N. The solutions included the active involvement of family and caregivers and differentiated capacity building within the service delivery model. Both of these solutions will be pursued in combination to address the POP. To maintain consistency and illustrate the iterative nature necessary to manage this change transition, the change implementation plan will utilize Cawsey et al.'s (2016) Change Path Model and Kotter's (1996) Eight-stage Model. To review, these models were previously identified as suitable frameworks for leading the change process. Short, medium and long-term goals were identified as integral components of the change implementation plan. Resource needs and anticipated limitations will be identified.

The primary framework to advance the necessary change implementation plan was identified as Cawsey et al.'s (2016) Change Path Model. Utilizing a structured, linear and planned approach through the Awakening, Mobilization, Acceleration and Institutionalization stages would allow for clear and incremental progression through the change process (Cawsey et al., 2016). However, it is important to note change as a complex, non-linear, iterative process (Styhre, 2002). Organizations are comprised of complex, value-laden, individuals who interact with each other and are influenced by environmental factors, ambiguity and feedback (Rhydderch, Elwyn, Marshall, & Grol, 2004). The very nature of such complex interactions suggests organizational change as a non-linear process (Beeson & Davis, 2000). Nonetheless, a planned, linear approach to move through the change process is suggested and advantageous within this OIP. For instance, a structured, linear approach was described in Chapter Two using Kotter's (1996) Eight-stage Model to help establish a communication strategy. A linear approach may also help to ensure transformational leadership responsibilities are promoted in a purposeful, sequential manner. Additionally, short, medium, and long-term goals, as outlined in Figure 3.1, could help to identify priorities for successful change implementation planning. Lastly, a planned, systematic approach is necessary to monitor and evaluate each PDSA cycle, explored later within Chapter Three. In summary, having a structured organizational process that builds on previous stages is a commonality amongst the frameworks and communication plans within this OIP, which helps to build cohesion in addressing the POP.

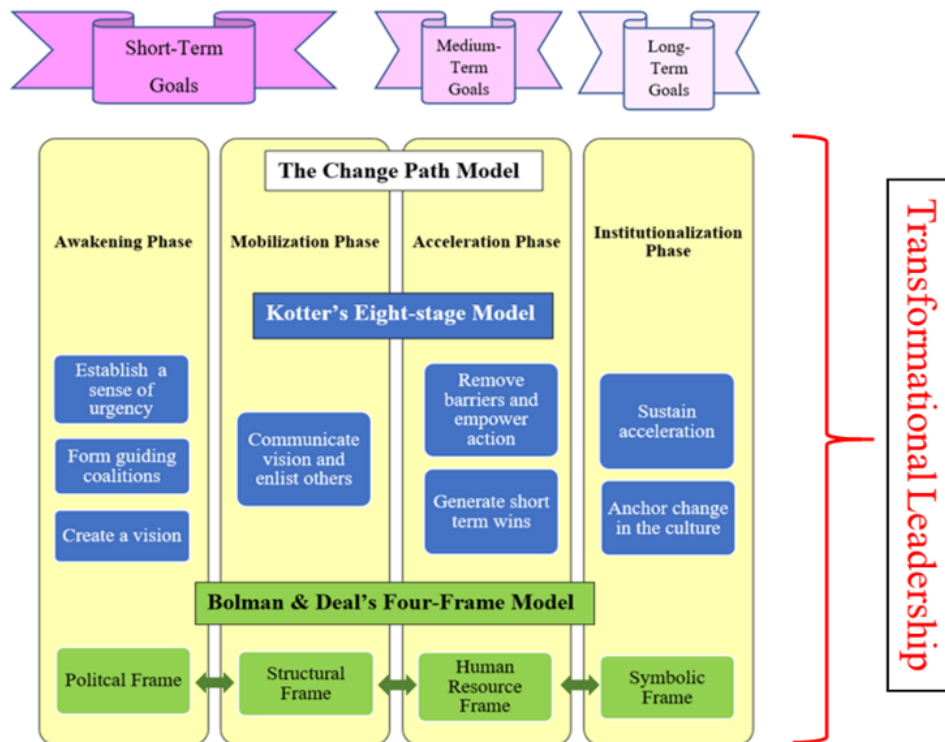


Figure 3.1. The alignment of Cawsey et al.’s (2016) Change Path Model and Kotter’s (1996) Eight-stage Model with short, medium, and long-term goals. Adapted from “Unfreezing change as three steps: Rethinking Kurt Lewin’s legacy for change management”, by S. Cummings, T. Bridgman, & K. G. Brown, 2016, *Human Relations*, 69(1), p. 42.

For the purposes of this OIP, short-term goals are defined as specific, actionable tasks initiated and completed within three months. Short-term goals align within the Awakening and Mobilization phases of Cawsey et al.’s (2016) Change Path Model, addressing resistance, encouraging communication, highlighting strengths and encouraging collaboration. In the following section, short-term goals will be further explored.

Figure 3.2 details the short-term goals within the Awakening and Mobilization phases of Cawsey et al.’s (2016) Change Path Model. The first identified short-term goal is to acknowledge the affective, cognitive and behavioral resistance within Service N (Aarons & Sawitzky, 2006; Erwin & Garman, 2010; Kebapci & Erkal, 2009). It is paramount that the Program Manager validate the concerns expressed by the clinicians about Rapp & Goscha’s

(2012) SBCM Service Delivery Model, to help build a vision for the change process. The Program Manager will use transformational leadership to reframe this resistance as an opportunity to improve service delivery. It is suspected that highlighting the resistance may elicit negative feelings and worry within Service N, concerning reprisal. Therefore, the Program Manager must deploy conflict resolution skills and maintain a safe environment to address the resistance without fear of reprimand, so the clinicians and the Program Manager can consider the two proposed solutions to the POP. The affective, behavioral, and cognitive resistance must also be reframed to the senior leadership team as an indication of where change is needed, and not as a performance management outcome. It is hoped that by improving the service delivery model, the clinicians will exhibit less resistance to using the model since the needs of the clients will be better addressed and clients may experience enhanced goal attainment.

Short-term goals also include ongoing discussions with the senior management team and other teams throughout the organization to ensure transparent and honest information exchange. Opportunities for open discussions can occur at team meetings, weekly resource groups, and staff meetings. It is at these meetings where internal data, file closure statistics, goal attainment outcomes, and fidelity scores are highlighted across the organization and the challenges faced by clients with a dual diagnosis are given attention. This also creates a forum to discuss the POP and establish a sense of urgency for change. As indicated in Figure 3.2, purposeful and continuous communication is evident throughout the timeline as both a tool for dealing with resistance (Kotter, 1995, 1996, 2004) and as a key contributor to successful organizational change implementation (Lewis, Schmisser, Stephens, & Weir, 2006).

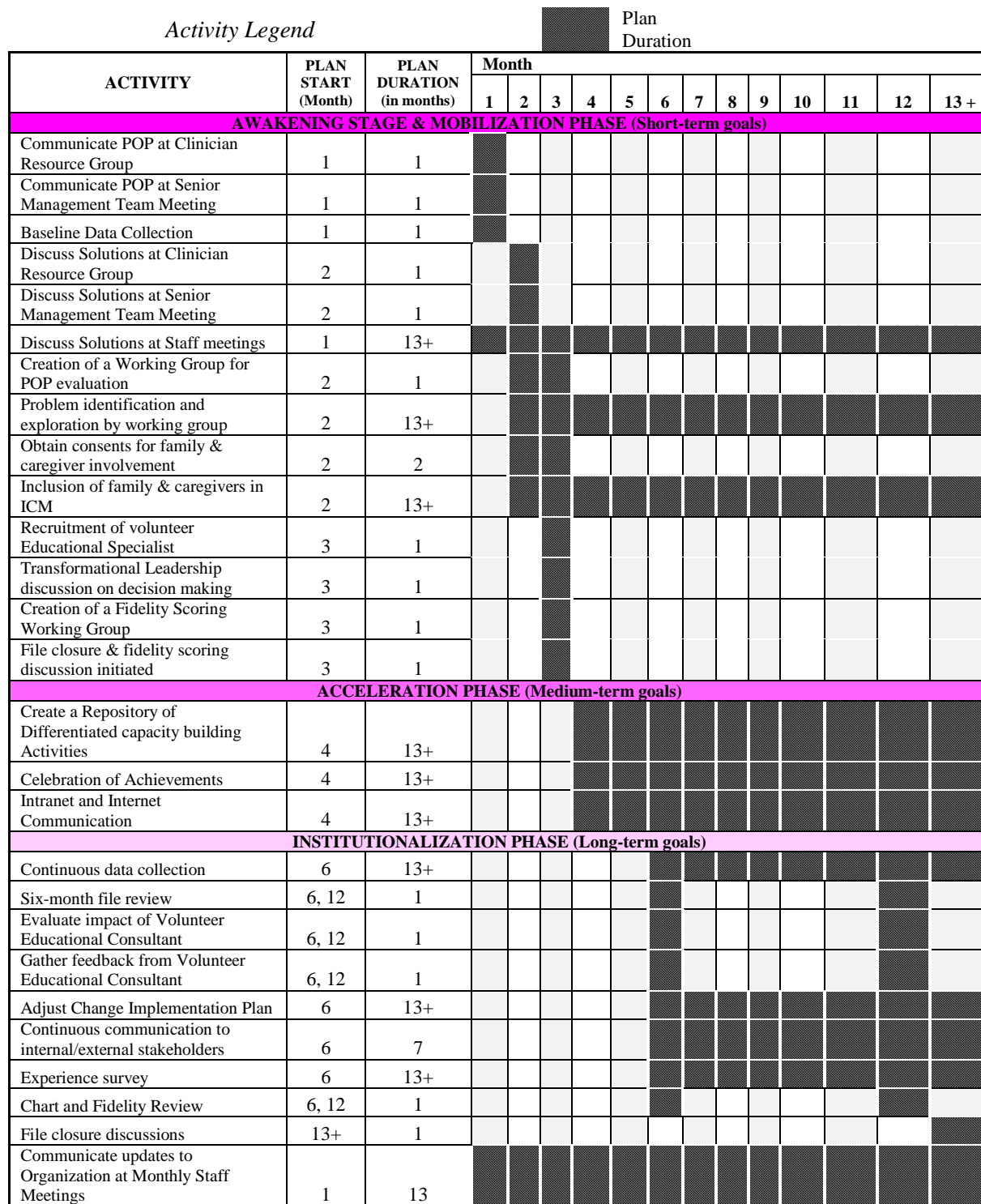


Figure 3.2. Change Implementation Plan Proposed Outline of short-term, medium-term and long-term goals.

Within the Awakening and Mobilization phases, additional short-term goals include the creation of working groups. The working groups will help to create the vision for the organization's future state through collaboration within the functional organizational structure (Galbraith, 2014). Participation invitations for working group membership would extend to all staff within the organization, promoting agency wide collaboration through transformational leadership opportunities.

One working group will be tasked to evaluate the two proposed solutions, exploring how each solution aligns with the mission, vision and values of the organization. Another working group will be tasked with problem solving how to score the Strengths Assessment and Personal Recovery plans. A consensus on new scoring procedures will help support the change plan agenda and the need for change. It would not be feasible to re-devise a unique fidelity scoring protocol for clients with a dual diagnosis within Service N, since doing so may introduce additional psychometric development challenges and data errors, as well as complicate data collection and comparability should a client migrate cohorts within the organization. Therefore, it is anticipated that following fidelity scoring discussions within the working group, that the outcome would support scoring secondary information from family and caregivers on the assessments, as primary information. A vision for active participation by family and caregivers, with consenting participants, would promote collaboration, support and goal attainment with continued participation throughout the course of service delivery. From a client-centered, strengths-based perspective, the involvement of family and caregivers and differentiated capacity building allows for meaningful access, diversity of learning, participation and goal progression for diverse learners (Katz, 2015). Furthermore, it is anticipated that the working groups would also come to this realization.

In addition to the formation of working groups, another short-term goal would be to recruit a volunteer educational specialist to develop differentiated capacity building aids with Service N clinicians. Existing partnerships with volunteers and adult learning organizations would be leveraged. Although recruitment of this educational specialist may seem a daunting task, the Program Manager has identified two such educational specialists already affiliated with Organization X, who could be willing to provide their expertise, in kind. As a non-profit organization, it is paramount that readily available, volunteer resources be explored and obtained. As indicated in Figure 3.2, recruitment efforts would commence in the third month.

Emphasizing the short-term goals within the Awakening and Mobilization phases also highlights potential limitations of the change implementation plan. Within the Awakening phase, as short-term goals are identified, there may not be support within the organization for another change initiative involving Rapp & Goscha's (2012) SBCM Service Delivery Model. Questions about this service delivery model as a best practice for clients with a dual diagnosis could surface. The lack of research on intensive case management approaches for clients with a dual diagnosis may impact and dissipate the sense of urgency in addressing the POP. It is also possible that there could be a lack of support for the two proposed solutions.

Within the Mobilization phase, there are additional limitations to the change implementation plan. Should a client fail to consent to the involvement of family and caregivers in the Strengths Assessment and Personal Recovery Plans, there is no change and current service delivery remains the status quo. Furthermore, involvement of family and caregivers is dependent on time availability, usefulness and accuracy of shared information and a willingness to participate. The involvement of others in service delivery introduces scheduling and information gathering challenges for clinicians. Despite efforts to recruit a volunteer educational specialist,

these efforts may fail and exclude differentiated capacity building as a solution to the POP. All changes to service delivery require support from the Board of Directors, which may take more time than anticipated. Furthermore, the Board of Directors would need to endorse both solutions fully for the change implementation plan to move forward. Despite these potential limitations, there exists underlying confidence in supporting the short-term goals within the Awakening and Mobilization phases to advance the change implementation plan.

Progression into the Acceleration phase, introduces medium-term goals. For the purpose of this OIP, medium-term goals are activities that commence approximately three months into the change implementation plan, ending after six-months. An integral medium-term goal within this phase is the continuous and systematic engagement and empowerment of internal and external stakeholders (Cawsey et al., 2016). Family and caregivers should be invited to continuously participate in the Strengths Assessment and Personal Recovery Plan and collaborative goal attainment actions. This collaboration will help to solidify coalition building within the client's support network through distributed leadership (Cawsey et al., 2016). Another medium-term goal would include the development of a repository of differentiated capacity building activities for use within the Strengths Assessment and Personal Recovery Plans. Some examples of differentiated instruction strategies may include instructional adaptations, visual materials, memory aids, augmented group arrangements, repetition, or a variety of verbal or gestural prompting throughout the instructional interactions (Landrum & McDuffie, 2010; Tomlinson, 2001). Additional differentiated capacity building adaptations can be found in Appendix E. Resource requirements would include materials, technology and time to create the aids.

An important consideration of the Acceleration phase is the acknowledgement and celebration of achievement milestones (Cawsey et al., 2016). Inherent within Rapp & Goscha's (2012) SBCM Service Delivery Model is the expectation and opportunity for clients to celebrate achievements along their recovery path (Rapp, 2014; Rapp & Goscha, 2012). This rewards-based environment within this service delivery model aligns well with the social work professional standards and ethics, providing opportunities to positively impact the lives of others, learn and work collegially (Rapp, 2014). The available reward mechanisms include verbal praise, written praise, and symbolic rewards like certificates of recognition and achievement (Cawsey et al., 2016; Rapp, 2014). These achievements can also be shared amongst family and caregivers, further reinforcing goal attainment behaviors. Success highlights and goal attainment could be celebrated throughout the organization, external stakeholders and with the ministry at annual general meetings, within annual reports, at monthly staff meetings, weekly staff gatherings and within Intranet and Internet advertisement. As indicated in Figure 3.2, celebrations of achievements can commence within the fourth month, and continue throughout service delivery.

There are limitations to consider within the Acceleration phase. Six of these limitations will be discussed. First, the lack of available resources may impact the implementation of differentiated capacity building activities. Any lack of resources could contribute to frustration, intolerance, and further resistance (de Jager, 2013). Second, a clinician's workload may impact time available to develop and implement differentiated capacity building activities. Third, the skill level of the clinician could impact the delivery of differentiated capacity building activities. Fourth, it may require time resources to build up the repository of activities to use with various clients, thus adding to time considerations and constraints. Fifth, the creation of the repository of

differentiated capacity building activities does not ensure client success or goal attainment. Lastly, success celebrations may not have the desired outcome. Each limitation would need to be explored within Service N, Senior Management Team, and within the two working groups, as potential influential factors affecting the success of the organizational change effort. Again, despite these limitations, there is confidence that the thoroughness of the change implementation plan, partnered with transformational leadership efforts, will drive change forward.

The final stage, known as Institutionalization, sets parameters for long-term goal creation. For the purposes of this OIP, long-term goals are activities that commence at six months to a year and beyond of the change implementation plan. It is within this phase that continuous assessment and monitoring expectations are measured, utilizing the PDSA cycle. By communicating long-term goal acquisition and using data to modify the change plan to encourage efficiency, sustained change can be successfully anchored into the organization (Cawsey et al., 2016). A more thorough discussion of appropriate PDSA cycles for this change implementation plan is discussed in the next OIP chapter section.

The importance of data collection can not be understated within the Institutionalization phase (Cawsey et al., 2016). Organization X has internal data available that compares pre and post Rapp & Goscha (2012) SBCM service delivery implementation outcomes. Long-term goals of the Institutionalization phase would include accurate data collection and monitoring of outcomes. Inherent within the model is an initial baseline data review and subsequent file assessment reviews every six months thereafter (Rapp & Goscha, 2012). Additionally, the working groups would be tasked with evaluating the impact of the volunteer educational consultant and goal attainment. Feedback from the working groups and the volunteer educational consultant would be integral in informing the necessary adjustments to the change

implementation plan and future modifications to service delivery. Communication of changes to service delivery, outcomes, chart and fidelity reviews would continue. Client, family, caregiver and clinician experiences would be collected. Through continuous assessment and monitoring within this final phase, change would be anchored within Organization X (Kotter, 1996). Thorough PDSA cycles, outlining evaluation, communication and data collection of these long-term goals, will be discussed in the upcoming OIP chapter section.

Limitations are evident with the Institutionalization phase. Continuous monitoring and evaluation will require time and human resources within Service N, the data management department and the Program Manager. Time management pressures could negatively impact on job performance and motivation, impacting resistance. With the smallest team in the organization, extended sick leave or change in position may drastically impact Service N and the ability to continue the change implementation plan. If data collection challenges surface, it may prove difficult to accurately measure outcomes within the six-month time line, as indicated within the model.

In summary, as illustrated within Figure 3.2, there are numerous short, medium, and long-term goals that align within Cawsey et al.'s (2016) Change Path Model. Layered within the change implementation plan is an emphasis on establishing the need and urgency for change through ongoing communication and involvement of stakeholders. The importance of effective communication to enlist and empower others, convey the vision and sustain change, are also components of Kotter's (1996) Eight-stage Model. Both models work together to help outline the change implementation plan to address the POP.

Change Process, Monitoring and Evaluation

As previously described in Chapter Three, Cawsey et al.'s (2016) Change Path Model was identified as the primary model to lead the change process. To progress the aforementioned change implementation plan, it is necessary to monitor and evaluate the change process. For the purposes of this OIP, monitoring is defined as the purposeful, continuous and systematic collection and analysis of information to help gauge progress towards a goal (Markiewicz & Patrick, 2016). Evaluation is defined as the intentional yet constant assessment of the quality and value of a program to determine whether goals and objectives have been met (Markiewicz & Patrick, 2016). Monitoring and evaluation are complementary, integrative, and necessary within this OIP to further the proposed organizational change effort (Markiewicz & Patrick, 2016). An effective way to align Cawsey et al.'s (2016) Change Path Model with change process monitoring and evaluation is to employ a Plan-Do-Study-Act (PDSA) cycle; a structure for iterative, testing of quality improvement initiatives (Bollegala et al., 2016; Donnelly & Kirk, 2015; Taylor et al., 2014). In the following section, the PDSA cycle will be explained, outlining monitoring and evaluation components. Additionally, a PDSA cycle for each identified solution will be explored. Tools and measures will be identified to help track, gauge progress, and assess change. The importance of refining each PDSA cycle will be discussed.

Of the four phases of Cawsey et al.'s (2016) Change Path Model, Institutionalization is the most pertinent for monitoring and evaluation purposes as it is within this phase where measurements assess progression of the change effort and modifications are suggested to enhance success probability. It is paramount that effective tools be identified to accurately capture measurable data to support the change implementation plan. Measurements influence the direction, content and the outcomes achieved by a change implementation plan (Cawsey et

al., 2016). Furthermore, change agents can utilize measures to make mid-course corrections to increase the prospects for successful change implementation (Cawsey et al., 2016). Pertinent to the POP are how measurements and processes are more likely to be accepted if these controls are seen as fair and appropriate, which may also reduce resistance (Cawsey et al, 2016).

In the following section, a PDSA cycle will be applied to each identified solution. A PDSA cycle is a method for structuring iterative development for change (Taylor et al., 2014). Within the PDSA cycle are four distinct, cyclic stages for leading the process of change (Donnelly & Kirk, 2015). Within the first stage of the PDSA cycle, known as PLAN, it is important to address the existence of a problem, identify desired outcomes and the proposed change improvement strategy (Bollegala et al., 2016; Donnelly & Kirk, 2015). In the second stage, DO, the execution of the plan over a specific time frame is identified (Donnelly & Kirk, 2015). This stage will involve both qualitative and quantitative data collection and monitoring. The identification of a leader within this stage to help drive data collection and ensure protocol adherence is pivotal (Bollegala et al., 2016). The third stage, STUDY, requires an evaluation of whether the identified solution to the POP was successful (Bollegala et al., 2016; Donnelly & Kirk, 2015). This also includes gathering feedback from involved stakeholders (Bollegala et al, 2016; Leis & Shojania, 2017). It is paramount that all data is analyzed and evaluated to help interpret the results and influence future PDSA cycle modifications (Bollegala et al., 2016). The fourth stage, ACT, helps to modify, expand, adopt or abandon the change that was tested and helps to inform the PLAN stage of the following PDSA cycle (Donnelly & Kirk, 2015; Taylor et al., 2014). The lessons learned within each PDSA cycle help to inform future PDSA cycles, which illustrates the iterative nature of the PDSA cycle method. Within Table 3.1 is a summary

of the specific tasks for each identified solution, to be completed within each stage of the PDSA cycle.

Table 3.1

PDSA Cycle tasks for the two identified solutions to address the POP

	Solution 1: Family and Caregiver Involvement	Solution 2: Differentiated Capacity Building
PLAN	<ul style="list-style-type: none"> • Test 15% of caseload using PDSA cycle (Treatment client). • Have conversations with clients about the option of involving family and caregivers with information gathering, goal identification and action planning. • Have conversations with family and caregivers about involvement. • Obtain consent for family and caregiver involvement. • Notify working group of PDSA cycle. • Notify fidelity scoring working group of PDSA cycle. • Working group to devise pre and post evaluation questionnaire for clients, family members, caregivers and clinicians. 	<ul style="list-style-type: none"> • Orient educational volunteer to Rapp & Goscha’s (2012) SBCM Service Delivery Model. • Have educational volunteer meet with clinician group and Program Manager for one day training. • Gather tools at end of training day to create a repository for clinicians. • Choose 15% of caseload (Treatment client) and up to five varying differentiated capacity building techniques to be utilized with the Strengths Assessment and Personal Recovery Plan. • Working group to devise pre and post evaluation questionnaire for clients and clinicians.
DO	<ul style="list-style-type: none"> • Complete pre-evaluation questionnaire with clients, family, caregivers and clinicians. Send questionnaires to Working Group and data management team for computation. • Have all clinicians implement the plan with 15% of caseload, identified as treatment clients. Treatment clients may only participate in one PDSA cycle at a time. • Identify a leader to drive data collection. • Have clinicians involve family and caregivers in the collection of information on Strengths Assessment and Personal Recovery Plan, as outlined in the plan. • Clinicians to meet with treatment clients, family and caregivers weekly over the course of four weeks to gather information. • Send data to Fidelity Scoring Working Group for computation. • Complete post-evaluation questionnaire with clients, family, caregivers and clinicians. Send questionnaires to Working Group for computation. 	<ul style="list-style-type: none"> • Complete pre-evaluation questionnaire with clients and clinician. Send questionnaires to Working Group and data management team for computation. • Have all clinicians implement the plan with 15% of caseload, identified as treatment clients. Treatment clients may only participate in one PDSA cycle at a time. • Identify a leader to drive data collection. • Have clinicians utilize differentiated capacity building activities with clients on Strengths Assessment and Personal Recovery Plans, as outlined in the plan. • Clinicians to meet with treatment clients weekly over the course of four weeks to gather information. • Send data Fidelity Scoring Working Group for computation. • Complete post-evaluation questionnaire with clients and clinician. Send questionnaires to Working Group for computation.

STUDY	<ul style="list-style-type: none"> • Compare treatment clients scores over last 4 weeks with their own scores on the Strengths Assessment and Personal Recovery Plan pre-PDSA cycle. • Compare treatment clients scores over the last 4 weeks with control clients scores within Service N. • Inquire how the scores compare with predictions. • What is learned from this PDSA cycle thus far? 	<ul style="list-style-type: none"> • Compare treatment clients scores over last 4 weeks with their own scores pre-PDSA cycle. • Compare treatment clients scores over the last 4 weeks with control client scores within Service N. • Inquire how the scores compare with predictions. • What is learned from this PDSA cycle thus far?
ACT	<ul style="list-style-type: none"> • Analyze whether more time is needed to complete assessments. Are there scheduling barriers, data collection issues, workload challenges? • Are the clinicians ready to implement the PDSA cycle with another 15% of their caseload? • Reflect on the last four weeks with clients, family, caregivers and clinicians. • Evaluate pre and post evaluation questionnaires and analyze results. • Recommendations for modifications to PDSA cycle prior to re-administering next PDSA cycle. 	<ul style="list-style-type: none"> • Analyze whether more time is needed to complete assessments. Are there scheduling barriers, data collection issues, workload challenges? What is the impact of the differentiated capacity building activities on data collection? • Are the clinicians ready to implement the PDSA cycle with another 15% of their caseload? • Reflect on the last four weeks with clients and clinicians. • Evaluate pre and post evaluation questionnaires and analyze results. • Recommendations for modifications to PDSA cycle prior to re-administering next PDSA cycle.

Fortunately, within Organization X, there are a variety of measurement tools available to track metrics throughout the agency. Quantitative tools include client and employee satisfaction survey results, intake and file closure data, fidelity assessment scores on the Strengths Assessment and Personal Recovery Plans, and re-uptake data regarding client’s re-entry into service after three, six- and twelve-months. Organization X also tracks and submits data to the ministry for reporting and accountability purposes regarding intake, goal attainment, hospitalizations and file terminations. Auspiciously, since 2016, Organization X has been collecting data involving Rapp & Goscha’s (2012) SBCM Service Delivery Model. Therefore, through triangulation, there is plethora of historical, quantitative data available for analysis. As the PDSA cycles commence, the working groups, data management team and Program Manager should be able to monitor and evaluate the effectiveness of both proposed solutions. By

analyzing the outcome measures, adjustments and changes can be made prior to the introduction of the next PDSA cycle. Possible adjustments and changes could include the addition of a data collection team if required, administrative assistance, additional treatment time exceeding four weeks or modifying the percentage of clients undergoing the PDSA cycle at one time.

Qualitative data from the clinicians was voiced during resource groups, team meetings, one-on-one discussions, and casual conversations. These informal conversations have captured personal disclosures and reflections of the service delivery model, presumed to have influenced resistance. Prior to the PDSA cycles commencing, the working groups will have devised client and clinician pre and post evaluation questionnaires, evaluating the perceived success of both proposed solutions. Additionally, it would be advantageous to use items from pre-existing, established questionnaires regarding resistance, to establish validity. The Resistance to Change Scale is a validated tool that will be provided to the working groups for consideration (Oreg, 2003). The Resistance to Change Scale accounts for behavioral, affective and cognitive individual resistance to change and further predicts reactions to change events (Oreg, 2003). Researchers have found that affective, cognitive and behavioral resistance are correlated, influenced by situational factors and individual disposition (Chung, Su & Su, 2012; Oreg, 2003; Szabla, 2007; Vince & Broussine, 1996). The nature of this research aligns well with this POP and OIP, thus the Resistance to Change Scale (Oreg, 2003) may provide structured questions to add to the pre and post clinician evaluation questionnaire. By using The Resistance to Change Scale (Oreg, 2003) within the PDSA cycle, measures of resistance could inform modifications to future PDSA cycles. In summary, all quantitative and qualitative information helps to monitor and evaluate the proposed change efforts. This information will also help to identify client outcomes, clinician perceptions and organizational outputs throughout the PDSA cycles.

Despite the fact that both proposed solutions are inherently different, there exist similarities within each proposed PDSA cycle that mutually reinforce the need for both solutions to the POP. Both PDSA cycles promote a significant percentage of clients on a clinician's caseload to undergo monitoring and evaluation, which is manageable, informative and can enable rapid assessment and flexibility to adapt to required changes (Taylor et al., 2014). Small scale treatment groups promote a learning environment, reducing the risk of harm to the clients, which is in line with the clinician's ethical standards (Taylor et al., 2014). By utilizing a small test group, there is an opportunity to build evidence for the proposed change plan and engage stakeholders as confidence in the intervention increases (Taylor, et al., 2014). Furthermore, each proposed PDSA cycle utilizes both qualitative and quantitative data collection over time by analyzing the results of pre and post intervention questionnaires and evaluation of fidelity scores. Monitoring and evaluating this data over time, helps to increase the awareness of influencing processes and the impact of the intervention (Taylor et al., 2014). Documentation is necessary with all stages of each PDSA cycles to support data collection, learning and reflection (Taylor et al., 2014).

Despite the pragmatic principles of the PDSA cycle, variations may exist within service delivery and intervention outcomes due to the Hawthorne Effect (Donnelly & Kirk, 2015; McCambridge, Witton, & Elbourne, 2014; Taylor et al., 2014). Simplified, the Hawthorne Effect is the consequence of research participation affecting behavior once there is an awareness of being studied (McCambridge, Witton, & Elbourne, 2014). Therefore, it is possible that the clinicians and clients may behave differently, knowing that their behaviors are being monitored and evaluated. Nonetheless, when interpreting results, it is important to consider bias inherent in research participation (McCambridge, Kypri, & Elbourne, 2014).

It is suggested that both PDSA cycles run concurrently within Organization X. To review, a PDSA cycle addressing family and caregiver involvement is required to facilitate information gathering on the Strengths Assessment and Personal Recovery Plan for service delivery if a client is unable to recall the information due to an intellectual impairment. Consequently, if information is absent from these assessments, the outcome negatively impacts service delivery. A PDSA cycle addressing differentiated capacity building is required as a bespoke communication requirement to involve the client in client-centered service. Having concurrent PDSA cycles will provide the information necessary to complete both assessments, in a manner that is inclusive of client need and involvement. Furthermore, both proposed solutions and PDSA cycles address the same problem of practice within this OIP. It is common place to test multiple changes with concurrent or overlapping PDSA cycles within healthcare, addressing multifaceted health care concerns like pain and anesthesia management, physician procedures and nursing protocols (Leis & Shojanian, 2017; Pelletier & Beaudin, 2018). Therefore, to suggest simultaneous PDSA cycles within the context of this OIP appears appropriate.

In summary, the PDSA cycle aligns well within Cawsey et al.'s (2016) Change Path Model, particularly the last phase known as Institutionalization. It is within this Institutionalization phase where change efforts are monitored and evaluated. It is important to use monitoring and evaluation practices within the PDSA cycle to help evaluate the effectiveness of each solution prior to the implementation of the next cycle. Concurrent PDSA cycles were suggested to provide the structure for iterative testing of the two proposed solutions (Taylor et al., 2014). Throughout each plan, do, study, and act stage, tasks were identified to assist in quantitative and qualitative data collection. In the next section, a comprehensive change process communication plan will be outlined, as well as next steps and future considerations.

Change Process Communication Plan

The etymological root of the word “communication” is the Latin word “communicare” which means to make common or to share (Simoes & Esposito, 2014). Therefore, communication is a process by which information is exchanged between individuals through a common system of words, symbols, signs, or behaviors (Communication, 2019). Communication is also a social process whereby individuals create and exchange meanings forming a culture (Simoes & Esposito, 2014). It is within this context of culture creation that communication is recognized as relevant to this OIP as a contributor to successful organizational change efforts (Armenakis, Harris, & Mossholder, 1993; Klein, 1994; Simoes & Esposito, 2014). The continuous exchange of messages within a strategic communication plan will help evolve organizational change efforts (Simoes & Esposito, 2014). Therefore, it is essential that an efficient communication plan outline effective communication methods within Organization X to advance change efforts.

A communication plan outlines a detailed and comprehensive process for what, how, and when to disseminate information to stakeholders (Newman, 2016). Ineffective communication plans may contribute to receipt of messages different from that which was intended, general misconceptions, negative attitudes and increased resistance adversely impacting the success of the change effort (Klein, 1994, 1996). Furthermore, an underdeveloped, poorly executed communication plan may create unnecessary crises within an organization (Newman, 2016). In an effort to mitigate barriers and unintended negative consequences of ineffective communication plans, it is recommended that Klein’s (1994) Eight Key Principles of Organizational Communication be utilized within this OIP.

Klein (1994) proposed eight key principles to be considered within organizational communication plans. Klein's (1994) Eight Principles are as follows:

1. Message redundancy is related to message retention
2. The use of several media is more effective than using just one
3. Face-to-face communication is preferred
4. The line hierarchy is the most effective organizational sanctioned communication channel
5. Direct supervision is the expected, more effective source of organizationally sanctioned information
6. Opinion leaders are effective changers of attitudes and opinions
7. Information that is consistent and/or reinforces basic values and beliefs is effective in changing opinions and attitudes
8. Personally, relevant information is better retained than abstract, unfamiliar or general information (Klein, 1994, p.27).

Although Klein's (1994) principles provide criteria to devise a robust communication strategy, the employee's receptivity for change is not accounted for. Frahm & Brown (2007) define change receptivity as both the positive and negative responses to change within an organization. To mitigate this factor within this OIP, it will be important to assess the level of clinician receptivity to change by incorporating self assessment measures within the pre and post evaluation questionnaire in the aforementioned PDSA cycles as well as provide opportunities for the clinicians to contribute within staff meetings and resource groups.

Klein's (1994) principles strongly align and support Kotter's (1996) Eight-stage Model for effective communication (Applebaum, Habashy, Malo, & Shafiq, 2012). Since Klein (1994) aligns with Kotter's (1996) model, Klein's (1994) eight principles also align with Cawsey et al.'s

(2016) Change Path Model, further supporting the iterative nature of the frameworks with in this OIP. Moreover, integration of Cawsey et al.'s (2016) and Kotter's (1996) models throughout the short, medium, and long-term goal identification within the change implementation plan helps to support the importance of communication while also aligning with Klein's (1994) Eight Key Principles of Organizational Communication. In the next section, Klein's (1994) eight principles will be described, with emphasis on how these principles will be used to advance the change effort within Organization X.

Message redundancy related to message retention. Frequent repetition of messages is a common strategy to highlight and convince others of one's point of view (Koch & Zerback, 2013). Success of any change effort depends on how effectively a communication plan is delivered (Frahm & Brown, 2007; Witherspoon & Wohlert, 1996). Therefore, it will be important within Organization X to communicate the change implementation plan throughout the agency, with the ministry, and to clients, family and caregivers. In the messaging, it will be important to stress how the two identified solutions align with service delivery intentions and the mission, vision and values of the organization. Furthermore, message retention is influenced by message repetition (Applebaum, Habashy, Malo, & Shafiq, 2012). Message repetition using a variety of media will further increase information retention (Cawsey et al., 2016). With repeated message encounters, an individual will tend to ascribe higher credibility to the message, known as the "truth effect" (Klein, 1994, 1996; Koch & Zerback, 2013). However, Koch & Zerback (2013) warn that excessive repetition may be considered less favorable resulting in the information being disregarded or dismissed.

Beatty (2015) suggests that a stakeholder map be utilized to segment stakeholders into quadrants to help devise a strategy for communication that mitigates overapplied information

sharing. Figure 3.3 depicts a stakeholder map. For the purposes of this OIP, Figure 3.3 utilizes the change drivers identified in Chapter One, and places these change drivers in quadrants according to degree of intensity of communication and degree of impact.

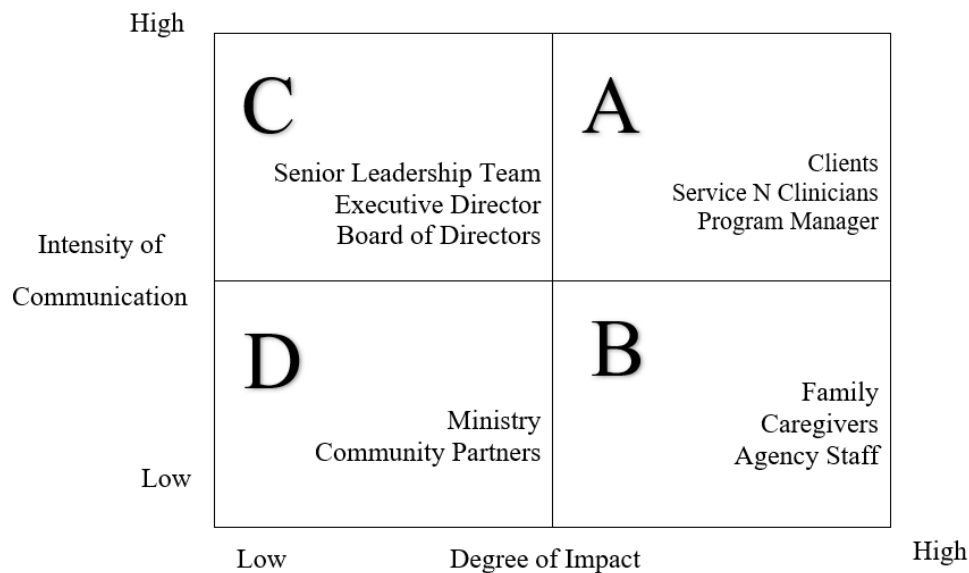


Figure 3.3. Stakeholder map for communication with change drivers within Organization X.

The change drivers in quadrant A, assert great influence and are most impacted by the organizational change effort. These include clients, the clinicians within Service N, and the Program Manager. These change drivers will need a higher degree of intense, frequent communication, which may help with information sharing, gaining commitment, and building understanding of the organizational change (Ackerman Anderson & Anderson, 2010). The change drivers in quadrant B, assert some degree of influence on the change effort but the objective with this group is to develop their cooperation with the change (Beatty, 2015). The intensity and frequency of the communication is less because they are indirectly impacted by the change effort. However, the communication should be appropriate to gaining commitment to the change effort (Ackerman Anderson & Anderson, 2010). The change drivers in quadrant C assert the highest degree of influence over the change effort. Without the support from the Senior

Management Team, Executive Director and Board of Directors, the organizational change effort would not move forward. Thus, communication should be scripted to inform and involve these change drivers to confirm their commitment to the change effort (Beatty, 2015). Such communication may include milestone events and outcome measures (Ackerman Anderson & Anderson, 2010). The change drivers in quadrant D, will be the least impacted by the organizational change effort and will need the least intense communication. These change drivers include the ministry and various community partners. These individuals simply need to be made aware of the changes to service delivery adequately achieved through quarterly communications on outcome measures (Beatty, 2015). By implementing the above stakeholder map tool, it is hoped that the content and frequency of communication is matched with change driver's direct impact by the change effort (Ackerman Anderson & Anderson, 2010; Koch & Zerback, 2013). Later in this chapter, a communication plan is presented that details how and when the change drivers will be informed of the change effort.

Using several media is more effective. Using various media to communicate information had advantages. For instance, using a variety of communication channels and mechanisms to disseminate information can increase memory of the message (Klein, 1994, 1996). Print media, like newsletters, fact sheets, reports, memos, and surveys can reach a large audience simultaneously and at a low cost (Beatty, 2015). Print media also provides a reference for information for future discussion (Beatty, 2015). Electronic media, such as emails, intranet, internet, and video conferencing is fast, timely and can also reach a vast audience (Beatty, 2015). Social media, like Facebook, blogs, and Twitter, can provide immediate information access and promote engagement and collaboration (Beatty, 2015). Fortunately, Organization X has a department dedicated to social media and has a well-established process to utilize this medium.

Therefore, it would be advantageous for the working group to explore how social media efforts can be enhanced to promote and engage others in the change effort.

Despite the advantages of using several media, there exist disadvantages. Using an array of media can be time consuming and perpetuate one-way communication (Beatty, 2015). In addition, Zimble & Feldman (2011) warn that the relative impersonality of emails could also increase skepticism within an organization, if this is the preferred method of information delivery. Therefore, to mitigate these challenges, it is suggested that print, electronic, and social media platforms be used together to relay organizational information (Beatty, 2015; Zimble & Feldman, 2011).

Face-to-face communication. Klein (1994, 1996) emphasized that face-to-face communication has the greatest impact compared to any other single medium. It is immediate, interactive, and encourages engagement and involvement of others, reinforcing distributed leadership (Klein, 1994, 1996). Face-to-face communication, when delivered through formal and informal dyadic communication opportunities, can help support and encourage employee productivity and satisfaction (Omilion-Hodges & Ackerman, 2018; Sias, 2005). Within Organization X, individual conversation, staff forums, resource groups, and staff meetings provide such opportunities and can help deliver an authentic message when paired with corresponding nonverbal features, like body language, voice, tone or intonation (Beatty, 2015). Although face-to-face communication is timely, engaging, and the preferred mode of communication, it relies on the skills and abilities of the communication deliverer to convey the intended message to the audience correctly (Beatty, 2015). Thus, it would be important for Organization X to ensure the delivery of the same message in face-to-face, informal and formal

communication opportunities during team meetings, staff gatherings and when engaged in one-on-one conversations.

Line hierarchy. Klein (1994, 1996) emphasizes the importance of communication delivery within the authority hierarchy since message delivery is influenced by the credibility and positionality of the communicator. As mentioned in Chapter One, Organization X has a strong hierarchical structure, therefore it is paramount that organizational communication be delivered by the Executive Director to the Board of Directors, ministry and staff, and by the clinicians of Service N in tandem with clients to families and caregivers. The line hierarchy is also evident when information is delivered by the Program Manager to the clinicians within Service N during resource groups, thought email communication, and during individual meetings. When communication is done purposely through a line hierarchy, the distribution of influence is used to engage and inform others in a two-way communication partnership (Klein, 1994, 1996). Later in this chapter, the communication plan details how and when the line hierarchy will be used to communicate the change effort by key change agents, including the Program Manager.

Direct supervision. Direct supervision and line hierarchy are closely linked since both responsibilities involve the transfer of information from one person to another (Klein, 1994, 1996). Within Organization X, the direct supervisor of Service N is the Program Manager. Direct supervisors are expected to be well informed with accurate and timely information (Klein, 1994, 1996). Additionally, the level of trust and understanding between a supervisor and an employee can elevate a supervisor's role within a communication strategy (Cawsey et al., 2016). Inherent within Rapp & Gosha's (2012) SBCM Service Delivery Model is the expectation of group and individual direct supervision to relay information regarding outcome measures, client

need, or an organizational improvement plan. As in a line hierarchy, the Executive Director will be responsible to directly inform the ministry and Board of Directors of change effort progress. Clinicians, who supervise clients, will inform family members and caregivers of pertinent information related to service delivery.

Opinion leaders. Klein (1994, 1996) acknowledges the importance of informal leaders in organizational communication who can assist in communicating a change strategy to a broader audience (Ackerman Anderson & Anderson, 2010). Within the context of this OIP, community partners, clients, other staff and the volunteer Educational Specialist are considered opinion leaders possessing an informal leadership capacity. Thus, these opinion leaders may be the conduit of information that could lead an organization through transformation (Ackerman Anderson & Anderson, 2010; Klein, 1996).

Consistent information reinforces values and beliefs. It is important to identify the values and guiding principles of the future organizational culture (Ackerman Anderson & Anderson, 2010). Once identified, communication regarding how the change strategy upholds these value and beliefs, is paramount for building a shared commitment and organization-wide transformation (Ackerman Anderson & Anderson, 2010). As mentioned in Chapter One, the values of the organization include a commitment to social justice, inclusivity, and collaboration (Organization X, 2017). By aligning the current values and cultural norms with the desired future state following change implementation, organizational communication can be developed that emphasizes and reinforces this information (Ackerman Anderson & Anderson, 2010).

Personally, relevant information. Klein (1994, 1996) posits that information which is familiar, common and personally relevant, like job-related information, is attended to and more efficiently retained. Lancker (1991) reports that personal relevance requires the establishment of

relationships with varying degrees of intensity, proving highly valuable from a biological, psychological and sociological perspective. Furthermore, within Bolman & Deal's (2013) Symbolic Frame, the relationships that bond people together help form the organizational culture. As meanings are attributed to symbols, activities, experiences and stories within the organization, these events become deeply rooted in a person's experience (Bolman & Deal, 2013). Within Organization X, the clinicians establish many relationships with fellow clinicians, employees, family, caregivers, community partners and clients. Through dialogue and storytelling, memories, feelings, thoughts, hopes, and fears are shared (Ackerman Anderson & Anderson, 2010). Through this communication and dialogue, information becomes personally relevant.

Communication helps build change readiness and commitment to organizational change (Armenakis, Harris, & Mossholder, 1993; Klein, 1994). Relevant to this OIP, the design and implementation of a communication plan may be an important factor in reducing resistance to change (Argyris, 1994; Lewis, Schmisser, Stephens, & Weir, 2006; Simoes & Esposito, 2014). Earlier in Chapter Three, short, medium, and long-term goals were identified within Cawsey et al.'s (2016) Change Path Model and Kotter's (1996) Eight-stage Model.

Table 3.2

Communication plan for Short-Term Goals

Short-Term Goals			
Establish sense of Urgency, Form coalitions, Create a Vision, Enlist others			
Audience	Communication Objective	Communication Channel	Frequency
Clinicians within Service N	Obtain consents for family and caregiver involvement	Face-to-face communication to discuss options with client	As frequently as required
		Face-to-face communication with family and caregivers for involvement	As frequently as required
Program Manager	Communicate POP at Clinician Resource Group, discuss Solutions	Print Media: fact sheet, report	At weekly resource groups for 4 weeks
		Face-to-face communication	At individual meetings over the course of the 4 weeks
	Creation of a working group and fidelity scoring working group	Print Media: Memo, newsletter.	Advertise request for membership for 3 weeks
		Electronic Media: Emails, posted on intranet	Send weekly emails requesting membership. Post on internal site
		Face-to-face communication	Communicate request for membership at weekly resource group, and at monthly staff meeting
	Data collection discussions with data management team	Print Media: Reports	Dialogue with data management team for data collection
		Electronic Media: Emails, posted on intranet	
		Face-to-face communication	
	Recruitment of a volunteer Educational Specialist	Print Media: Newsletter	Advertise request for volunteer Educational Specialist for one month in print, electronic and social media
		Electronic Media: Emails, posted on intranet	Communicate request at monthly staff meetings to general staff
		Social Media: Posted on Facebook, Twitter, blogs	Post on social media with weekly check ins and updates provided
		Face-to-face conversations with volunteer contact and clinicians	Schedule a time to meet with both volunteer contacts, dialogue with clinicians at weekly staff meetings and during individual meeting times.
	Transformational leadership decision making	Face-to-face conversations with clinicians	At weekly resource groups for 4 weeks
		Face-to-face conversations with Senior Management team	At monthly Senior Management Team Meeting
		Face-to-face conversation with ED, Print Media including reports and fact sheets	COMPLETED and endorsed
Executive Director	Communicate POP at Senior Management Team Meeting	Print Media: fact sheet, report	At monthly Senior Management Team Meeting
		Face-to-face communication	At monthly Senior Management Team Meeting and during monthly staff meetings to all employees
		Electronic Media: Emails, posted on intranet	Request that ED distribute weekly emails (more if required) to summarize work to date and forecast upcoming plan.

In summary, as seen in Table 3.2, the short-term goals outlined within the Change Implementation Plan have been further grouped into communication objectives. It is recommended that face-to-face communication, and various forms of print, electronic, and social media be used to communicate to stakeholders. Additionally, frequent communication should

occur on a consistent basis. By aligning Klein’s (1994) principles with Kotter’s (1996) communication strategies, coalitions are formed, urgency established, and others are enlisted to create a future organizational vision.

Similarly, as depicted in Table 3.3, medium-term goals have been further grouped into communication objectives. Face-to-face communication has been suggested as the predominant form of communication by clinicians, the Program Manager and the Executive Director to stakeholders. Print and electronic media will help to disseminate information, aimed at removing barriers, empowerment, and celebrating successes.

Table 3.3

Communication plan for Medium-Term Goals

Medium-Term Goals			
Remove barriers, empower others, short term wins			
Audience	Communication Objective	Communication Channel	Frequency
Clinicians within Service N	Create a repository of Differentiated-capacity building activities	Face-to-face communication with volunteer Educational Specialist	As frequently as required
		Print Media: fact sheet, reports	At weekly resource groups to share with fellow Clinicians, monthly report submissions to Ministry
	Celebration of achievements	Face-to-face communication with clients on goal achievement	At each meeting
		Face-to-face communication with family and caregivers	As frequently as required
Program Manager	Celebration of achievements	Electronic Media: Emails	As frequently as required to family and care-givers
		Electronic Media: Emails	As frequently as necessary to clinicians
		Electronic Media: Emails	Weekly email updates to all-staff
		Face-to-face communication with clients on goal achievement	As frequently as possible
		Face-to-face communication with Service N	At weekly resource groups
		Print media: Reports	At individual meeting times with clinicians
		Print media: Reports	Contribute celebration of achievements to monthly, internal newsletter
Face-to-face communication with volunteer Educational Specialist	Submit monthly report to Ministry which highlights achievements		
Executive Director	Celebration of achievements	Face-to-face communication with volunteer Educational Specialist	As frequently as possible
		Electronic Media: Intranet	Submit updates to data management department to upload to Intranet on a monthly basis
		Face-to-face communication with the organization	Celebrate achievements at monthly staff meetings
		Electronic Media: Emails	Updates in monthly correspondence
		Print Media: monthly reports	Updates in monthly correspondence

Table 3.4 outlines the communication plan for long-term goals, with a focus on data collection, monitoring and evaluation, as is seen in the Institutionalization phase (Cawsey et al., 2016). The purpose of communicating data results is to sustain momentum for the change effort and anchor change within the organization (Kotter, 1995, 1996). It is recommended that data results be distributed most efficiently in print or electronic media formats with face-to-face communication reiterating important findings and progress. Likewise, satisfaction surveys will be available in print and electronic media formats, reinforced by informal and formal dyadic communication.

Table 3.4

Communication plan for Long-Term Goals

		Long-Term Goals		
		Sustain acceleration and anchor change		
	Communication Objective	Communication Channel	Frequency	
Audience				
Clinicians within Service N	Continuous data collection	Print Media: Strengths Assessment and Personal Recovery Plans	At each meeting	
		Print Media: fact sheet, reports	At weekly resource groups to share with fellow Clinicians, monthly report submissions to Ministry	
	Celebration of achievements	Face-to-face communication with clients on goal achievement	At each meeting	
		Face-to-face communication with family and caregivers	As frequently as required	
		Electronic Media: Emails	As frequently as required to family and care-givers	
	Distribution of experience survey	Print Media: Experience Survey	Distribute experience survey to clients at baseline, six months and 1 year	
File closure discussions	Face-to-face communication	At weekly resource groups with Program Manager		
Program Manager	Continuous data collection	Print Media: Strengths Assessment and Personal Recovery Plans	As frequently as necessary	
			At six month file reviews	
		Electronic Media: Data base	As frequently as necessary	
	Evaluation of volunteer Educational Specialist	Face-to-face communication with volunteer Educational Specialist	As frequently as necessary	
		Print Media: Satisfaction Survey	At six months and 1 year	
	Continuous communication to stakeholders	Electronic Media: Emails	Send email updates as necessary	
		Face-to-face communication with family, caregivers, community partners	As frequently as possible	
		Social Media: Facebook, Internet	Submit updates for posting on social media as required	
	Distribution of experience survey	Print Media: Experience Survey	Distribute experience survey to clinicians at baseline, six months and 1 year	
	Change Implementation Plan updates	Face-to-face communication		As frequently as necessary
				At monthly staff meetings
			At monthly senior management team meetings	
Electronic Media: Emails			As frequently as necessary	
Print Media: Newsletters			Within monthly newsletters	
Continuous communication to stakeholders	Print Media: Reports	Within quarterly reports to the Ministry		
	Electronic Media: Emails	Updates in monthly correspondence		
	Print Media: monthly reports	Updates in monthly correspondence		
Executive Director	Change Implementation Plan updates	Face-to-face communication	At monthly staff meetings to the whole organization	
			At monthly senior management team meetings	
			At monthly Board of Director's meeting	
		Electronic Media: Emails	As frequently as necessary	
	Print Media: Newsletters	Within monthly newsletters		
	Print Media: Reports	Within quarterly reports to the Ministry		
	Print Media: Annual Report	Annually within Annual Report		
	Celebration of achievements	Face-to-face communication	At monthly staff meetings	
Electronic Media: Emails		As frequently as required		
Print Media: Annual Report		Annually within Annual Report		

In summary, this chapter outlined a year-long change implementation plan for the two identified solutions to address the POP; family and care involvement and differentiated capacity building. Short, medium, and long-term goals were explored within the context of Cawsey et al.'s (2016) Change Path Model and Kotter's (1996) Eight-stage Model. Two concurrent,

iterative PDSA cycles were recommended. The chapter concluded with a detailed communication plan for all goals, grouped into communication objectives. Various communication methods were identified to advance the change process. The final section of this OIP will explore next steps and future considerations.

Next Steps and Future Considerations

Next steps. This OIP has explored the following POP: what leadership theories and frameworks could address the resistance within Service N in adopting Rapp & Goscha's (2012) SBCM Service Delivery Model? This OIP outlines a comprehensive approach in addressing this resistance by carefully considering leadership theory, leader attributes, present organizational structure, two identified solutions and PDSA cycles, measurement suggestions and a communication plan. In an effort to advance this OIP, there are five suggested next steps in leading the change process.

First, the Program Manager must share this OIP with the Executive Director of Organization X. The Executive Director, as the hierarchical leader of the organization, is an instrumental figure in the change process and must agree to address the POP, as outlined. Since the Executive Director was supportive of this OIP at inception, it is presumed this leader will fully support the change effort. Once the change effort is supported by the Executive Director, a presentation to the Board of Directors for endorsement, will occur.

Second, this OIP will be presented to the Senior Management Team. This team, inclusive of Directors and other Program Managers, should be informed of the proposed changes to program delivery for clients within Service N. The involvement of these leaders will help to build organizational understanding for change. Furthermore, these leaders will be instrumental

in communicating the new vision throughout the entire organization and in the adoption of the organizational change effort throughout Organization X (Frahm & Brown, 2007).

Third, the clinicians within Service N need to be acknowledged for the team's efforts over the last two years, and informed that a plan has been devised, founded on the team's suggestions to improve service delivery for persons with a dual diagnosis. It is anticipated that Service N clinicians will be eager to engage in conscious, shared, intentional strategies to improve service delivery and organizational transformation (Ackerman Anderson & Anderson, 2010).

Fourth, recruitment of the volunteer Educational Specialist is vital in addressing a solution to the POP. As previously mentioned, two such individuals are already affiliated with the organization and have voiced their willingness to assist with differentiated capacity building opportunities. It will be important to engage Human Resources to assist in the recruitment process to mitigate delay in actioning the change plan. Once the volunteer is recruited, the volunteer Educational Specialist should familiarize themselves with client needs, meet with the clinicians and become knowledgeable in Rapp & Goscha's (2012) SBCM Service Delivery Model. Furthermore, training days should be scheduled to help facilitate engagement and learning between the volunteer and Service N clinicians in differentiated capacity building.

The last step highlights communication. The change effort should be communicated throughout the organization at staff and resource group meeting and in print, social, and electronic media. By utilizing transformational leadership tenets, continuous communication could help establish why the change is necessary, create urgency to act, clarify expectations, motivate others, and identify desired outcomes (Ackerman Anderson & Anderson, 2010).

Future considerations. In addition to implementing the changes outlined throughout this OIP, there exist three future considerations. First, as indicated within this OIP, the reliability and validity of Rapp & Goscha's (2012) SBCM Service Delivery Model with persons who have a dual diagnosis, has not been established. Therein lies an opportunity to collaborate with Kansas University to research the efficacy of this particular strengths-based intensive case management service delivery style with persons with a dual diagnosis. Such research could have far-reaching implications for the clients within the organization and within the broader community. Furthermore, such research has the potential to further the academic literature on mental health and strengths-based, intensive case management supports for persons with a dual diagnosis.

A second future consideration could be for Organization X to grow Service N capacity within the agency. As stated previously, Service N is the smallest program within the organization, serving what can arguably be one of the most complex cohorts of clients to serve. Statistics Canada (2018) reports that the number of people with developmental disabilities is growing within Ontario. By growing the program, more clients could receive strengths-based, intensive case management support, while simultaneously addressing community need for more mental health supports for persons with a dual diagnosis.

The last future consideration would be to explore the use of family and caregiver involvement and differentiated capacity building with other clients throughout the Organization. Persons with acquired brain injury, substance use challenges, and various learning disabilities are also amongst the clients that receive services within Organization X. It is plausible that the two identified solutions to the POP could also benefit other clients within the organization. Assessment, evaluation and research would be necessary to establish reliability and validity of

two identified solutions; family and caregiver involvement and differentiated capacity building. Furthermore, the potential to enhance mental health supports through collaboration with identified community supports and tailored service delivery, is possible by utilizing an enhanced version of Rapp & Goscha's (2012) SBCM Service Delivery Model. Perhaps this could be a future OIP topic for consideration and exploration.

Chapter Three Conclusion

In conclusion, Chapter Three outlined a year-long strategy to address the POP. Short, medium, and long-term goals were identified and aligned within Cawsey et al.'s (2016) Change Path Model, to advance the change implementation plan. Layered within this change implementation plan, was an emphasis on purposeful communication, as highlighted within Kotter's (1996) Eight-stage Model. Monitoring and evaluation strategies were recommended within two concurrent PDSA cycles to advance the change effort. A detailed PDSA cycle was applied to both solutions addressing the POP; family and caregiver involvement and differentiated capacity building. The communication plan utilized Klein's (1994) Eight Key Principles, identifying advantageous communication methods within organizational change efforts. Next steps and future considerations addressed implementation strategies for the change effort within Organization X and the broader community. This OIP will conclude with an overall OIP conclusion and a reflective, leadership purpose.

OIP Conclusion

In 2016, Rapp & Goscha's (2012) SBCM Service Delivery Model was adopted as a best-practice by Organization X, for intensive case management service delivery. To summarize, this service delivery model specified a set of principles, methods, and tools used to deliver strengths-based, intensive case management service. All clients within Organization X received this

specific form of intensive case management, which focused on identifying, securing, and sustaining a range of individual strengths and environmental resources to support psychiatric recovery from mental illness (Rapp, 2014; Rapp & Goscha, 2012). This service delivery model assumes that individuals have a level of functional ability to participation in the process of strengths-based, intensive case management. However, clients with a dual diagnosis within Service N appeared to be struggling within the model. As a result, the clients were scoring lower on fidelity measures and client goal attainment. Consequently, the clinicians within Service N, demonstrated resistance towards adopting Rapp & Goscha's (2012) SBCM Service Delivery Model. Implementing a separate, intensive case management service delivery model within Service N was not a possibility, particularly due to funding restrictions. Therefore, this OIP was structured around the requirement of utilizing Rapp & Goscha's (2012) SBCM Service Delivery Model to address this resistance.

Chapter One introduced Organization X, outlining the organizational structure and leadership composition. The scope and agency of the Program Manager within the organizational structure was explored. The gap between the current and future organizational state was described, with an emphasis on improving intensive case management service delivery for persons with a dual diagnosis, within the organization. Factors affecting the POP were explored and change drivers identified.

Within Chapter Two, transformational leadership was identified as necessary for leading the organizational change process. With a focus on planning and developing a strategy for organizational change, the remainder of Chapter Two identified the framework, a gap analysis tool, and two solutions which best addressed the POP. The two solutions to the POP are family and caregiver involvement and differentiated capacity building. Ethical considerations were

explored in relation to inclusion of persons with a dual diagnosis, leadership and change influences.

Chapter Three outlined a detailed change implementation plan for Organization X to address the resistance within Service N. The change implementation plan identified short, medium, and long-term goals over a year-long period, two concurrent PDSA cycles, and a detailed communication plan, each highlighting strategies required to manage the change effort.

In conclusion, this OIP document not only has the intention of benefiting Organization X, but also has the potential to improve goal attainment for persons with a dual diagnosis while also improving strengths-based, intensive, case management service delivery. The last section of this OIP will provide a reflective, leadership purpose.

Reflective, Leadership Purpose

My leadership purpose, inclusive of my strengths, passion, knowledge and abilities, helps identify my personal leadership insignia; “With tenacity, create purposeful change”. This OIP journey has clarified for me, my purpose as a leader and my role in igniting any change effort. With an empathetic understanding for persons with a dual diagnosis and my unfettered commitment to excellence, I am excited about my role in leading the change effort outlined throughout this OIP. My hope is that this change initiative will positively impact the clients, the clinicians, the organization and the broader community.

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Appendix A

Strengths Assessment

Current Strengths	Individual’s Desires, Aspirations	Past Resources – Personal, Social & Environmental
Home/Daily Living		
Assets – Financial / Insurance		
Employment/Education/Specialized Knowledge		
Supportive Relationships		
Wellness/Health		
Leisure/Recreational		
Spirituality/Culture		

What are my priorities? _____

Adapted from *Strengths Model: Project Leader’s Workbook*. (2014). Lawrence, KS: Kansas University Press.

Appendix B

Personal Recovery Plan

My goal is:				
Why is this goal important to me?				
What will we do today or before our next meeting?	Who is responsible?	Date to be accomplished?	Date accomplished?	Comments
1.				
2.				
3.				
4.				
5.				

Adapted from *Strengths Model: Project Leader's Workbook*. (2014). Lawrence, KS: Kansas University Press.

Appendix C

Strengths Assessment: Questions to Explore

Current Strengths	Individual’s Desires, Aspirations	Past Resources – Personal, Social & Environmental
Home/Daily Living		
<ul style="list-style-type: none"> • What is the address where you live currently? • What personal assets related to daily living do you have? • What are the special attributes about your home you enjoy? 	<ul style="list-style-type: none"> • If you could change one thing about your current living situation what would it be? • What do you need to make your living situation easier? • What would your ideal living situation be? 	<ul style="list-style-type: none"> • List each place where you have lived before, and length of time you lived there? • What was your favorite living situation and why? • Are there things you had in the past that you do not have now but you would like again?
Assets – Financial / Insurance		
<ul style="list-style-type: none"> • What is your current income? • How much money do you receive from ODSP? • How much money do you receive from family and friends on a monthly basis? 	<ul style="list-style-type: none"> • What is important to you regarding your finances? • Are there benefits that you are entitled to but are not getting? • How would you like your finances to be different? 	<ul style="list-style-type: none"> • What was your income in the past? • Did you have additional financial support in the past and from who? • Are there past resources you used that you are not using currently?
Employment/Education/Specialized Knowledge		
<ul style="list-style-type: none"> • What are your current productive activities? • What is your highest level of education? • What is important to the person about the activities they are currently engaged in? 	<ul style="list-style-type: none"> • If you could be or do anything, what would it be? • What activities do you enjoy? • What job would you like? 	<ul style="list-style-type: none"> • What types of activities were you involved in? • What kinds of vocational services have you received? • What work situations have you found most enjoyable and why?
Supportive Relationships		
<ul style="list-style-type: none"> • Who do you spend time with? • What organizations/clubs do you participate in? • Where, outside of your home, do you feel most at ease? 	<ul style="list-style-type: none"> • Is there anything that you would like to be different in your social life? • Are there any areas of your life you would like more support in? • What organizations/clubs would you like to join? 	<ul style="list-style-type: none"> • Who are the important people in your life? • With who and where did you socialize before that you do not currently? • Did you belong to any past groups, organizations or clubs?
Wellness/Health		
<ul style="list-style-type: none"> • What are the names and addresses of your doctor, counsellor, psychiatrist etc.? 	<ul style="list-style-type: none"> • What health items are you currently working on? 	<ul style="list-style-type: none"> • What health and wellness resources have you used in the past?

<ul style="list-style-type: none"> • What medications are you currently taking? • What symptoms of your illness do you experience? 	<ul style="list-style-type: none"> • What mental health activities are you currently addressing? • If there anything about your physical or mental health that you would like to learn more about? 	<ul style="list-style-type: none"> • What are your patterns of hospitalization? • What are precipitating factors to involuntary hospitalizations?
Leisure/Recreational		
<ul style="list-style-type: none"> • What do you like to do for fun? • What are your talents? • If you could do anything you wanted for one day, what would you do? 	<ul style="list-style-type: none"> • What are some fun things you like to do, that you are not doing currently? • Are you interested in meditative pursuits? • What is your vacation dream? 	<ul style="list-style-type: none"> • Where did you participate in your leisure activities? • What past activities did you enjoy? • What about the activities did you enjoy?
Spirituality/Culture		
<ul style="list-style-type: none"> • Is there anything in your life that brings you a sense of comfort? • What do you have faith in? • What gives you strength to carry on in times of difficulty? 	<ul style="list-style-type: none"> • Would you like to join an organized group for support? • Which social supports would you like to be a member of? • Would you like to join a fellowship with others? 	<ul style="list-style-type: none"> • Were you involved in community services in the past? • What did you have faith in? • What has given you strength in the past?

What are my priorities? _____

Appendix D

Personal Recovery Plan Example

For Ann

Assisted by Rick and Sam

Date: 7/06/18

<p>My goal is: (<i>Supportive Relationships</i>): “I want to keep my son”.</p> <p>Why is this goal important to me? “He is everything to me”.</p>				
What will we do today or before our next meeting?	Who is responsible?	Date to be accomplished?	Date accomplished?	Comments
1. Attend medical clinic next Tuesday with son	Ann and Rick	7/10/18	7/10/18	Spoke with the doctor and blood work ordered. Results will be reviewed.
2. Met with CAS worker together to review plan for maintaining custody. (Ann will call and make the appointment).	Ann and Rick	7/15/18	7/17/18	Ann was reminded to call CAS and coached through the call. It was a good meeting. Ann is hopeful that the plan will work.
3. Attend meeting for parent training skills at CAS on Thursday from 6 – 7pm. Buy bus tickets and take bus.	Ann	7/20/18	7/22/18	Ann was reminded to purchase bus tickets. Arrived early. Met a friend at the meeting. Went out for coffee after the meeting.
4. Take one afternoon next week and work on my drawings. (Mom will watch the baby).	Ann and Mom	7/23/18	7/23/18	Ann drew three pictures, all for the baby. She enjoyed herself.

Adapted from *Strengths Model: Project Leader’s Workbook*. (2014). Lawrence, KS: Kansas University Press.

Appendix E

Multiple intelligences and learning styles applied to Strengths Assessment and Personal

Recovery Plan

Multiple Intelligence and Learning Styles	Strengths Assessment idea	Personal Recovery Plan idea
Verbal-linguistic: learns by reading, hearing, seeing words, speaking, writing, discussing ideas	Having a check list of strengths to choose which are appropriate for each individual	Having others write down the steps to the plan and completion dates or use voice-to-text technology
Math-logical: learns by working through patterns, relationships, classifying and categorization	Having various strengths available to the client, and they must categorize them into the proper category	Writing down action items on cue cards/flash cards/iPad, and sequencing the order in which to complete
Spatial: learns best with pictures, colors, visualization or drawing	Have strengths represented as pictures that a client can choose from or watch a video	Using a visual calendar and mark off completion of tasks and due dates on calendar in red marker (hard copy or electronic)
Body-kinesthetic: learns best through moving, touching, processing through body movements	Bring client to a gym and have them lift a 5, 10, and 15 lb weight or exercise using Nintendo Wii	Have client go to a bus station and purchase bus tickets with cash or play a novel sport on Nintendo Wii
Musical: learns best through rhythm, melody, singing, listening to music	Expose client to different meditative types of music and record preferences	Beatbox action plan steps
Interpersonal: learns best by sharing, comparing, relating to others	Create a group where clients can complete Strengths Assessment together and share strengths	Work collaboratively with family and caregivers to complete Personal Recovery Plan
Intrapersonal: learns best when working alone, self-paced	Complete the strengths assessment independently	Omit "date to be accomplished" on the Personal Recovery Plan
Naturalistic: learns best working in nature, exploring	Have client purchase a plant/fish/small animal and have client care for it	Walk to an appointment in the community

Adapted from Denig, S. (2004). Multiple intelligences and learning styles: Two complementary dimensions. *Teachers College Record*, 106(1), 107.