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Managing the Paradoxes of Strategic Change

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ABSTRACT *The strategic management literature provides numerous examples of strategy but offers little guidance for leaders in a top management team to fashion the strategy and use it to prompt large-scale change. We propose such a methodology in this paper and field test it in a state department of mental health, devising a way to downsize and merge state hospitals to release $70 million annually for community-based treatment.*

Introduction[1]

We suggest an approach to fashion, integrate, and implement innovative strategic change in an organisation and then conduct a field test of these ideas. We embrace the old saying attributed to Mao: 'True knowledge emerges in the dialogue between a scholar and a practical man' and critical theorists who note that discourse has power (e.g. Denzin, 1989; Patton, 1990; Rosenau, 1992). This leads us to use 'on-line' experiences that combine development with field testing to validate our ideas. We believe that viable ideas emerge when development and application occur in waves, or cycles, with insight about what to do growing from attempts at use in real situations.

We present our ideas as propositions that identify what facilitators should do to realise a successful strategic change. The propositions offer a way for facilitators to use teams, made up of key players, to make an issue diagnosis, fashion innovative responses to key issues, and align strategical action using a 'Kiva' group process (Nutt & Backoff, 1992). Even though some important questions are not considered, we believe that our propositions will be useful in prompting a much-needed discussion of ways to carry out strategic change in an organisation. We illustrate key points with an application of our process to devise a strategy that reconfigures state mental hospitals in response to legislatively mandated transfer of funds to community-based treatment. We describe the task and then discuss the actions taken to make the required strategic changes, thereby illustrating key ideas in our process.

The Test Site: Ohio's mental health system

Historically, states provided mental health services through a network of state-operated hospitals. Ohio's mental health act of 1988 called for a change

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from an inpatient to a community orientation and a transfer of control to community mental health boards that were to operate an integrated system of care. Treatment of patients was to be done in the least restrictive setting, close to family and friends, which called for a large-scale expansion of community-based treatment.

To carry out the change, the Ohio Department of Mental Health (ODMH) was to divert funds away from state hospitals for local use in community-based treatment. The amount of funds to be placed under local control was to gradually increase during the years from 1990 to 1996. Each community mental health board was required to reimburse the state for its use of their hospitals. By 1992, the state of Ohio had a very mixed bag of experiences in attempting to implement the law. Most local boards had accepted responsibility and had begun to draw funds away from state hospitals. State hospitals were changing to accommodate the new payer and payer expectations, but there was conflict and even litigation about the funding distribution.

When the project reported here began, the threat of downsizing had put many jobs at risk, including those of hospitals' CEOs and treatment professionals. Reform was to bring some closures and mergers, making the pain of change very real to ODMH. Within the next several years, 10 hospitals had to be closed to reduce costs. This called for reducing hospital beds from 1800 to 1200, placing clients and some staff in community-based treatment organisations; cutting FTEs from 3200 to 2500; ensuring that the remaining beds were used to treat only the most acutely ill individuals and court-ordered hospitalisations; for a total reduction of $70 million annually. These changes had to consider unionised employee groups threatened with layoffs and outplacement. Mental health client or patient car quality was also a concern, as was the state's new role in the provision of forensic mental health services. No large state had successfully achieved such a broad-based change designed to deal with the provision of inpatient care within a community system.

The broad strokes for this effort had been set during a 1993–1994 project called 'inpatient futures'. The department had wanted to build a consensus about the role of hospitals in each region to incorporate local differences and develop agreements with unions to transition staff to outpatient settings. There was considerable disagreement about the significant issues to be addressed and how best to move forward, as summarised in Table 1. We initiated our process to develop an action plan that could carry out the needed changes.

Some Missing Pieces in Making a Strategic Change

Strategic change for the 'inpatient futures' project calls for uncovering key issues and fashioning strategic responses (Bryson, 1988; Nutt & Backoff, 1992). However, the strategic management literature says little about how to uncover issues or to fashion and then integrate ideas for strategic change to cope with key issues, drawing on the knowledge of, and building support in, key stakeholders (see, for example, Ansoff, 1984; Tichy, 1983, Quinn *et al.*, 1988; Thompson & Strickland, 1995). The theoretical arguments supporting the importance and role of issues, strategy development, and strategy integration are considered here.

Table 1. Initial views of 'inpatient futures' project[1]

	Where are we now?	Key issues	Suggested actions(s)
1.	Which hospital chain and re-engineering model should be used? (Solution displaces finding motivation for action)	How do we pilot preferred models?	Choose between chain model and a flexible one to refit hospitals
2.	Doesn't understand the questions (Ambiguity and uncertainty surround what to do)		
3.	Must shift 600 clients and $70 million to community (Fact focus, seeing a plan as the issue)	Need plan that specifies what to do	Have a retreat to finalise specifics
4.	Hospital inpatient futures aims not accepted by hospital staff (Rejects the need to act/alienation/what's input)	Disconnectedness from central office (CO)	Reach agreements about who should be involved
5.	Failure to devote resources to community needs (e.g. poverty, violence, stigma, homelessness, joblessness, and diminished personal regard) (Reformer, wants major system change)	What are true needs?	Working time frame to meet needs
6.	Dual system of care in ODMH without considering ways to improve services (Hospital advocate, fearing CO takeover)	CO uses this as opportunity to centralise with a power grab	Hospital people must participate in planning
7.	No direction about what's to be done (Formulation and implementation concerns)	Understanding CO and hospital risks	Power struggle limits action because CO and hospitals lack a common ground to work from
8.	Previous action proposals ignored (sends report) (Single-issue advocate)	'Kids' are the issue	New plan for kids that implements ODMH role in 'Family Stability Incentive Fund Program'
9.	Individual hospitals are taking action (Uncoordinated action abhorred, but no ideas)	Budgets in hospitals and need to determine hospital role by area	No ideas

Note: 1. Collected by a survey of key stakeholders. Lists typical responses from many respondents.

Most strategic management approaches begin by uncovering issues, which identify events and trends that call in to question an organisation's strategy. Issues provide 'statements of intention' that suggest an arena in which to search for strategy (Drucker, 1954; Maier, 1970; Mintzberg *et al.*, 1976; Nutt, 1984). The arena must be selected carefully because an overly narrow one limits search; an inappropriate one misdirects search. Statements of intention emerge from the diagnostic acts of key people (Lyles, 1981; Nutt, 1993).

Overcoming blind spots and biases in this diagnosis (e.g. Dutton & Jackson, 1987; Kolb, 1983) is a first step in a strategic change process.

Things get complicated because important issues frequently have the entanglements of 'wicked problems' (Ackoff, 1981). Although the interrelationships among issues make it impossible to treat them separately, most strategic management approaches deal with issues one at a time. In addition, many approaches to strategic management mix issues and action (e.g. Thompson & Strickland, 1995). This tends to limit search, which makes innovation unlikely (Starbuck, 1983). This suggests that the members of a top management team (TMT) must uncover issues and issue relationships, and keep issue diagnosis and strategy development separate. The literature says little about how a TMT can uncover and articulate issues and issue relationships. Our approach shows how diagnostic issues spring from tensions that are both endemic to the life of most organisations and the social constructions of key people in these organisations. Attempts to deal with key tensions produce a dialectic between current and future possibilities that contain the seeds of change. We show how dialectical thinking by a TMT can be used to reveal possibilities that have the potential for realising successful strategic change.

A public organisation's strategy, such as ODMH, is made up of clients, services, service provision networks, collaborative arrangements, funding and oversight mechanisms, skills and abilities, and image or how the organisation is regarded by important oversight bodies (Nutt & Backoff, 1992). Issues point to internal and external strengths, weaknesses, opportunities, and threats that can influence the current strategy's effectiveness (Bryson, 1988). Analytical, stakeholder, and adaptive approaches have been suggested as ways to craft a strategy in response to these issues. Analytical approaches examine the organisation's portfolio of services to determine how well its 'service lines' fit with its mandates to find resource allocation that changes the mix of service, clients, service networks, funding, skill, and image that improves this fit (Henderson, 1979; Ring, 1988; Porter, 1985; Thompson & Strickland, 1995). Stakeholder approaches (Freeman, 1984; Mason & Mitroff, 1981) look for individuals in a position to influence the organisation or to put demands on it. To satisfy important stakeholders' interests, a strategy is sought that deals with interrelated social, political, and economic considerations. Adaptive approaches (e.g. Hofer & Schendel, 1979; Steiner, 1979; Ansoff, 1984) find and then fill gaps between the demands of oversight bodies and the organisation's capacity to respond. These approaches, and others like them, say little about how an innovative strategy can be fashioned. As Morgan (1988) points out, an innovative strategy is often found in the *gaps* between current services, service provision vehicles, funding mechanisms, and skills. The strategic management literature says little about how a TMT should search these gaps for creative strategic responses to issues that merit attention.

We offer such an approach by drawing on ideas found in the negotiation (e.g. Fisher & Ury, 1981; Lewicki & Littener, 1985), systems (e.g. Nadler & Hibino, 1990), problem-solving (e.g. Maier, 1970; Rothenberg, 1979) and organisation theory (e.g. Morgan, 1988) literatures. When used to deal with disputes, integrated negotiation attempts to move people in conflict beyond position-based bargaining to see their larger interests. Win–win solutions

deal with these larger interests without disadvantaging either of the disputing parties. We move the focus of negotiation from individual to organisational concerns to uncover strategic moves for an organisation with a win–win solution. Unlike position-based bargaining to uncover strategic moves for an organisation, organisational actors often fail to see crucial competing concerns in a strategic change. We show how the concerns of organisational power centres arise from these conflicting values and beliefs. Some of these conflicts are hidden and many are not fully understood. By making concerns explicit, an issue tension emerges. The competing concerns that make up an issue tension are similar to positions held by stakeholders in a negotiation. Then tension representation provides a platform to search for strategic win–wins that deal with conflicting concerns found in key issue tensions.

Typically, organisations face several important issues. Strategic responses to such an issue agenda must be carefully integrated so the actions taken complement one another, and avoid working at cross-purposes. As Senge (1990) observes, strategic actions can have an amplifying or a dampening effect and leaders frequently do little to coordinate and stabilise their actions to cope with these interrelationships. When strategic change is treated as an incremental process in which small moves are made through time (e.g. Quinn *et al.*, 1988), the benefits derived from a coordinated response to a bundle of important strategic issues can be lost. Organisations that fail to make key strategic connections may also lose significant opportunities (Collins & Porras, 1994). The power of synergy is recognised in many treatments of strategic management (e.g. Thompson & Strickland, 1995), but little has been written about how to coordinate strategic actions.

Our approach seeks to fill some of the holes in the strategic management literature. We show how a TMT can uncover strategic issues described as tensions, create a win–win strategy for a bundle of issue tensions, and fashion a strategic circle of change that connects strategic actions so synergy among these actions will amplify the strategic win–win. We also present ways to involve interested parties in this process, which increases the prospect of implementation. Table 2 summarises key steps in our process and supporting techniques to involve key people. Table 3 summarises propositions suggested by these steps. Next, we discuss our three process stages and illustrate their key steps with the 'inpatient futures' project.

How to Make an Assessment

Strategic issues arise from significant trends and events, inside or outside an organisation that influence the organisation's ability to reach a desired future (Ansoff, 1984). Issues guide the search for strategic solutions. We call for issues to be crafted as tensions.

Proposition 1: considering issues as tensions increases the prospect of realising a successful strategic change.

Public sector organisations, such as ODMH, are continually bombarded with budget cuts, limitations of prerogative, changes in those eligible for services, changes in service intensity, fee controls, union activism, erosion of image, shifts in the views of oversight bodies, judicial rulings, law suits, leadership

Table 2. Summary of the strategic change process

Process stages	Process steps	Supporting techniques
Assessment	1. Issue agenda building	
	a. Elicit concerns	SRGP1
	b. Find opposing concern to form an issue tension	Dialectics
	c. Test agenda for missing values	Tension framework
	d. Add to issue agenda	
	2. Set priorities	Voting techniques
	3. Identify priority issue tension and related tensions	ISM, cognitive mapping
Strategic actions	4. Map the win–win situation	Hampden-Turner maps
	a. Find lose–lose outcomes	Creativity
	b. Find best win–lose outcomes	Stakeholder teams
	c. Find compromise strategy	Negotiation
	5. Find win–win strategy	SRGP
	a. Move up the diagonal	
	b. Create a bigger space	Systems laddering
	c. Modify context	Reverse figure and ground
	d. Search for win–win	Creativity, dialectics
Integrating strategic changes	6. Create cycle change	Spoke and wheel
	a. Offer win–win strategy (intervention)	
	b. Tensions arrayed as spokes in the wheel	
	c. Identify actions that amplify the win–win and deal with concerns in the adjacent issue tension (amplification)	Cybernetics 2
	7. Fine tune cycle	Find and root out perverse incentives
	8. Co-align with other change cycles	Co-alignment

Note: 1. SRGP: silent reflective group process using Kiva approach (see Nutt & Backoff, 1992).

changes, and still other developments. When such developments appear to be holding the organisation back or offer a significant advantage they become a 'concern' and prompt action.

Many concerns arise simultaneously in an organisation and acquire advocates who call for different types of action. Taking action to deal with one of these concerns can be viewed as dismissing the other, prompting opposition in stakeholders with strong views. For example, public schools may have to reduce spending because of a levy failure and, at the same time, be forced to deal with edicts from a state legislature that requires schools to mount new programmes to improve the graduation rate of disadvantaged groups. Responding to one of these concerns without considering the other creates a potentially explosive situation in which the school system can be battered by the media and various interest groups.

To avoid these difficulties, we treat issues as *tensions* between competing concerns to point out conflicting interests and values within an organisation

Table 3. Summary of the propositions[1]

Assessment		
Forming issues	(Proposition 1)	Considering issues as tensions increases the prospect of realising a successful strategic change
Testing issue agendas	(Proposition 2)	An issue agenda that reveals and portrays all issue tension types for management is more apt to produce a successful strategic change
Issue synergy	(Proposition 3)	Strategic responses that coordinate actions to manage issue tensions with interdependent relationships are more apt to produce successful strategic change
Strategic actions		
Motivating change	(Proposition 4)	Finding a win–win strategic action that increases the net payoff to all key power centres will improve the prospects of successful strategic change
Small moves	(Proposition 5)	Identifying lose–lose, lose–win, and compromise strategy before seeking a win–win strategy improves the prospects of successful strategic change
Minimal constraints	(Proposition 6)	A strategy search with minimal constraints produces the best prospects of successful strategic change
Context reversal	(Proposition 7)	Context reversal helps to uncover innovative possibilities for win–win strategy, which improves the prospect of successful strategic change
Integrating strategic changes		
Intervention	(Proposition 8)	Integrated actions that respond to concerns found in related issue tensions and contribute to the win–win strategy increase the prospect of successful strategic change
Amplification	(Proposition 9)	Several trips around the change circle must be completed before prospects of a successful strategic change begin to improve
Energy drains	(Proposition 10)	Energy drains in a change circle will reduce the prospect of a successful strategic change
Maintenance	(Proposition 11)	Fine tuning actions in a strategic change circle will increase the prospects of continuing to realise the benefits of strategic change
Alignment	(Proposition 12)	Aligning the actions called for across strategic change circles will increase the prospect of organisational success

Note: 1. The producer–product relationship of 'necessary but not sufficient to' takes the more measurable form of 'improving the prospects of' in the propositions. This enables a process researcher to test the propositions by comparing the proportion of cases that do and do not follow the actions that are called for.

or between the organisation and its environment. The tension specifies conflicts inherent in most organisations that prompt important issues. Defining issues as tensions captures the tangled web of political and social forces that push and pull organisations in many different ways at the same time (Cameron, 1986). For example, a community mental health centre may have to deal with court orders to treat clients and with funding agents that call for budget reductions. If these concerns are not managed as a tension, the mental health agency can be whipsawed by powerful people in its authority network. Tensions also arise from arguments offered by media, professional

interest groups, and branches of government that support or oppose an action. For example, calls to privatise a state bureau of workers' compensation are made by some groups and opposed by others. Strategic leaders who deal with but one of the opposing concerns, and ignore the other, create potentially dangerous situations.

Identifying an Issue Agenda

Issue tensions are socially constructed from endemic concerns. 'Internal–external', 'integration–differentiation', 'headquarters-field', and 'goal incongruency' tensions often arise in organisations (Quinn, 1988; Mason & Mitroff, 1981; Hampden-Turner, 1981; Pacanowsky, 1994). The way in which such tensions take shape tends to be organisation specific. To appreciate these differences, we uncover issues before any interpretation is attempted. This is done because the shared experiences of key people, such as a top management team, create beliefs about organisational values that must be understood before strategic change can be started. We begin issue identification by uncovering these beliefs and then look for generic categories that seem to capture these views to find hidden difficulties. An issue agenda is constructed by following steps 1 to 3 listed in Table 1.

The Kiva Group Process and Teams

For the 'inpatient futures' project, we used a Kiva approach and a 'silent reflective group process' or SRGP. SRGP calls for people to silently uncover ideas, list the ideas one idea at a time, discuss the ideas, and then prioritise the ideas (Delbecq *et al.*, 1986; Nutt, 1992). Kiva is based on a decision-making structure attributed to the Hopi Indians. In a Kiva, tribe members are arrayed outwards in rings of increasing status. Only the innermost ring is allowed to talk. Things begin as the first ring, made up of tribe elders, discusses an issue. After this discussion, the elders move to the outer most ring. All groups move in one ring. The elders listen as each group moves to the center and discusses what they think they heard. This continues until the elders return to the inner ring. Armed with reflections on reflections, they decide the issue, with the others listening.

We used the Kiva idea to create what we call an 'inner circle' and 'outer circle' for the ODMH project. The inner circle was made up of people representing key sources of knowledge and important interest groups. The outer circle included the remaining stakeholders so all of the key players could have a significant role in the strategic change process. We developed rules to guide the exchange of ideas between the 'circles' to allow concerns to surface and be articulated as an efficient meeting was being conducted.

The 'inner circle' had 10 key stakeholders and an 'eleventh' chair. The inner circle members were selected by ODMH's executive committee, in consultation with others in the department. The inner circle included five members representing the top management of hospitals (CEOs and nursing directors) and five central office staff members with important hospital liaison and coordinating roles. Invitations were sent to other stakeholders (e.g. other hospital CEOs, medical directors, and people in key hospital

central office liaison roles, such as district managers) to join the outer circle. Inner circle membership was fixed; outer circle members varied depending on topic and interest. The agenda was faxed or e-mailed to all interested parties. The outer circle members could elect someone to fill the eleventh inner circle chair for any meeting. Each inner and some outer circle members also took on liaison responsibilities to key interest groups. As concerns developed, these people were encouraged to become part of the outer circle to express them at the next meeting. These steps were taken to facilitate implementation via participation (e.g. Likert, 1967; Nutt, 1987).

The Kiva process allowed reflections of the outer circle members to be expressed to the inner circle. The outer circle members were not allowed to talk during the process. To express their ideas, an outer circle member could pass a note to an inner circle member at key process points, such as idea generation. The inner circle member receiving a note was obligated to interpret the idea and include it with his or her own. Also, both the inner and outer circle members were asked to vote on priorities. The inner and outer priorities were compared. Presenting differences in priorities when they appeared created pressure to resolve differences before moving forward.

Steps Taken

The inner circle uncovered issues and formed them as tensions. Using a SRGP as noted above, the inner circle was asked to identify anticipated and actual conditions that, if continued, will influence ODMH's ability to reach the desired future of budget reallocations. Issue tensions are formed by asking inner circle members to examine each concern and then find the most significant concern that was pulling in the opposite direction. Examples were used to describe what was wanted, such as medical school department's loss of a subsidy from a state legislature that was paired with increased demands to serve low-income patients in a state-subsidised clinic (Nutt & Backoff, 1992). After a voting step, a prioritised list of issue tensions was identified.

Examining the Issue Agenda

An initial agenda is tested to find overlooked issue tensions.

Proposition 2: an issue agenda that reveals and portrays all issue tension types for management is more apt to produce a successful strategic change.

To look for hidden issue tensions, facilitators examine the initial list of issue tensions with a framework of generic issue tensions. These generic issue tensions came from noting the type of direction and attention focus people use to recognise developments (Quinn & Rohrbaugh, 1983; Morgan, 1984, 1986; Nutt & Backoff, 1993). Direction shows where scanning is focused and attention focus indicates how perceptions influence what is seen. Four types of developments called equity, preservation, transition, and productivity

Table 4. Strategic issue tension types

	Attention direction	
Type of attention	Internal	External
Open and flexible	Human resource needs (equity)	Innovation and change (transition)
Regulation and control	Maintenance of tradition (preservation)	Effective processes (productivity)

emerge from the type of direction and attention focus used for scanning (see Table 4).

Inwardly directed open/flexible scanning picks up *equity* developments. This type of scanning is drawn to the network of relationships that run an organisation and interpretations of what needs fixing. Both clients and people who run the organisation must be treated fairly. For insiders, equity concerns may call for an investment in peoples' growth and their support of one another. Insiders interpret the service needs and demands of clients and how to meet them. Concerns about clients often take shape as calls for new services to meet needs, increased staffing, or more training.

Control or regulation, inwardly directed, emphasises developments that maintain tradition, prompting *preservation*. Control is imposed on events or trends, calling for a return to a previous status quo or maintaining a current one. The need to maintain tradition underlies concerns that arise from these developments. The value of tradition is often interpreted in terms of the preservation of cultures, practices, or treaties forged and validated over the life of the organisation.

Change or *transition* developments emerge from open and flexible scanning directed externally. Reading environmental signals, the strategic leader looks for needs that must be met or opportunities that provide leverage. The organisation would be called on to adapt to exploit the opportunity or meet the need, creating a transition. Transition concerns suggest how the organisation must change, such as new service that can provide the organisation with larger budgets or greater influence.

Scanning externally with regulatory perspective stresses rationality and how things are done. Developments are recognised in terms of changes needed to enhance *productivity*, seeking the best possible output level. Concerns that arise from developments posed in productivity terms often call for process modifications that can improve performance or increase efficiency.

Equity, preservation, transition, and productivity are always potential concerns for an organisation. To show them as tensions, they are paired with one another to define 10 types of issue tensions, shown in Table 5. Four tensions are made up of a single type of development. For example, a tension between employers stressing job readiness and universities calling for adequate college preparation was observed by the leadership of a state board of regents for higher education (Nutt & Backoff, 1993). This produces a 'productivity–productivity' tension because each party is calling for a productivity-based corrective action. The other six issue tensions stem from combinations of different developments (see Table 4). In the board of regents

Table 5. The 10 issue tension types

Type	Often signalled by:	Illustration[1]
1. Equity–equity	Whose interests will be served	Clashes between clients and/or key providers who have different interests
2. Transition–transition	Several plans for change	Each plan calls for a different set of actions that appear to benefit a different set of stakeholders
3. Productivity–productivity	Disputes over diagnostics	Several different measures of performance are being used by stakeholders that suggest different actions
4. Preservation–preservation	Groping for core values	Allocating resources among agencies that have different sources of funding, some that support traditional services, others with innovative services
5. Preservation–transition	Dealing with inertia during change	Inertia causes organisations to get sucked into a degrading cycle with no apparent way to break out
6. Productivity–equity	Reconciling cost cutting with human commitments	Agencies forced to cut costs but must do so in accordance with union contracts and commitments to key people
7. Equity–transition	Who gets what during change	Disputes over anticipated utility surpluses in which new services or internal operations are being claimed by political appointees
8. Transition–productivity	Meeting demands during change	Agencies facing a budget cutback that are attempting to mount new programmes
9. Preservation–productivity	Squeezing a stressed system wedded to tradition	Agencies with a critical need to increase output proposes change that is resisted by people who argue that the new norms violate important agency traditions
10. Preservation–equity	When fairness clashes with tradition	When Congress instituted performance-based compensation for civil servants implementation was stalled by rules that called for compensation based on seniority

Note: 1. Examples of a single tension are difficult to provide. This stems from our basic premise: an issue agenda is connected or implicated in all of the other tensions. Each of the examples that we use to illustrate the tensions can be reframed to make it fit any of the other tensions. We believe that all issue tensions have this characteristic.

example, the learners' needs (equity) can be in tension with college preparation (productivity), and educational system change (transition) can be in tension with inertia in higher education (preservation). Also, educational needs (equity) and inertia (preservation) can be hidden in claims by students and faculty that slide past the other party. The learners' needs (equity) can also be in conflict with the need for new taxes (transitions), which will be resisted by people who represent firms in the behind-the-scenes manoeuvring with the board. An issue agenda is tested by classifying the initial list of issue tensions as one of the 10 types. A fully diagnostic issue agenda considers each of the 10 issue tension types (see Table 4).

Table 6. Issue tensions in the ODMH 'inpatient futures' project

1. Equity–Equity
   (A) Centralising versus decentralising of hospital functions after downsizing (who does what after mergers and closures)[1]
2. Productivity–Productivity
   (D) System versus client views of service quality (clients have views of quality that differ from provider views)[1]
3. Transition–Transition (no tensions identified)
4. Preservation–Preservation (no tensions identified)
5. Preservation–Transition
   Control versus cooperation and collaboration as downsizing occurs (control old way of doing business or developing new ones)
6. Productivity–Equity
   Supplier interests and needs versus customer(client) needs (desires of local community MH system may not serve people who need services
   Rational decisions versus people's fear of losing jobs (the best way to change may provoke unnecessary fear)
7. Equity–Transition
   Central office support versus re-engineering hospitals (concern that central office would hold back resources needed to reconfigure remaining hospital)
   Dealing with the needy versus governmental limits on service capacity (can people's needs be met with expected level of public funding)
8. Transition–Productivity
   (C) Downsizing versus maintaining quality (less capacity means fewer people can be helped)[1]
   (B) Integrated system of MH care versus backup care systems during change (a fear that massive change would drop needy people or create a hiatus in their care)[1]
   Delivery of services versus expectations to cut cost (oversight bodies, such a legislature, expect cost savings even if service capacity is eroded)
9. Preservation–Productivity
   (E) Agreements with unions versus continuing to offer hospital services (union contract provisions prohibiting RIFs had been set aside by ensuring union members' outplacement in community MH centres. Delays or refusals to accept transfers would force retention of staff and old practices)[1]
   Control mental health services throughout system versus new arrangements that bring in more revenue (central office staff continuing to monitor service throughout the system limits what can be done to seek out new sources of revenue)
   Forensic patients only versus hospitals competing for patients (forensic, court order hospitalisations may displace the capacity needed for new patient base being sought to create revenues)
   Standardise patient care versus flexibility (agreeing to past service treatment norms absorbs capacity that limits flexibility in the treatment of various patient groups)
10. Preservation–Equity (not observed)

Note: 1. Top priority, letter codes indicate tensions included in Figure 2.

After discussion and consolidation of ideas, the ODMH 'inpatient futures' project uncovered 10 issue tensions as shown in Table 6. The missing tensions of transition–transition, preservation–preservation, and preservation–equity were examined to find if they represented hidden concerns. This list seemed comprehensive because ODMH had worked through transition, preservation, and equity concerns after the legislation of 1988. Transition was given and preservation of the old system was not possible. It was also understood that change would bring with it equity and fairness difficulties that must be managed.

Finding Key Issue Tensions

Many issue tensions deal with core values and practices that are interrelated. These relationships must be captured to find the best place to start as well as crucial interdependencies among issue tensions that must be considered in any change attempt.

Proposition 3: strategic responses that coordinate actions to manage issue tensions with interdependent relationships are more apt to produce successful strategic change.

To capture the interdependent relationships among issue tensions, maps (Axelrod, 1978; Weick, 1979; Eden & Radford, 1990; Warfield, 1990; Nutt & Backoff, 1992) of precedence (which issue tension must be managed first) and producer–product (which issue tension is more likely to produce or result from another) were created from the views of the inner circle. These relationships are illustrated by arrows that connect all pairs of tensions in Figure 1.

The precedence relationship indicates priority, which issue tension comes first. The issue tension with the most arrows pointing outwards is a candidate

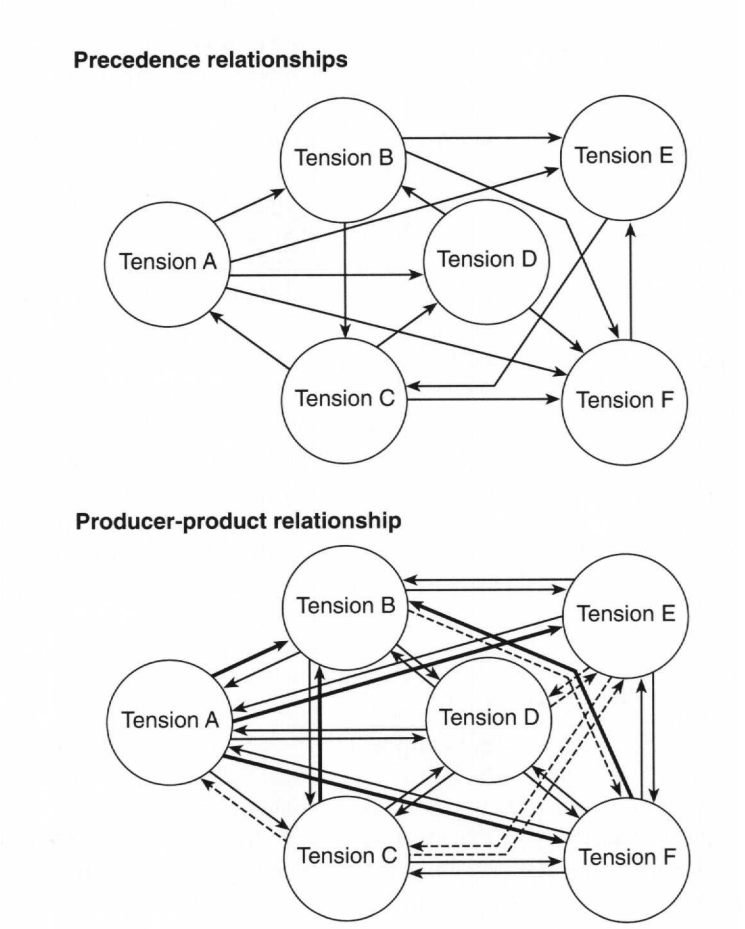

Figure 1. Finding priority tensions.

from the priority issue tension. The precedence relationship in Figure 1 suggests that tension A is the priority issue tension. Most of the arrows point outwards, suggesting that tension A precedes the others. The precedence diagram also uncovers reciprocal relationships. Note that tensions B, C, and D are interdependent (Figure 1). To deal with such interdependencies tensions must be considered together as strategy is crafted.

The producer–product relationship is described by two arrows between each pair of issue tensions shown in Figure 1. The thickness of the arrow is used to indicate the strength of the relationship. Solid lines depict producer relationship and dotted lines depict a product relationship. A tension will be a producer when more dark lines are found coming from it. For example, in Figure 1, tension A is the producer of tensions B, E, and F. Because these relationships are strong (as signified by the dark line) and because tension A is not the product of other tensions, the producer–product relationship in Figure 1 identifies tension A as the priority tension. Also note that tension B is the producer of tension C and the product (or result) of dealing with tensions A and F. This shows that tensions F, B, and C must be considered together to manage these interdependencies as strategy is crafted.

Interdependent precedence (e.g. tensions B, C, and D) and producer–product relationships (e.g. tensions F, B, and C) identify issue tensions that cannot be considered separately during strategy development. Such tensions are synergistic and call for a strategy that coordinates the actions taken to deal with them (Senge, 1990). (Issue tensions with interdependent relationships become 'related tensions' that make up a strategic change circle, discussed later in the paper.)

The inner circle in the 'inpatient futures' project identified the issue tension relationships shown in Figure 2. Priority tensions tend to precede others, and tend to be a producer of most other tensions and not their product. This suggested that the priority or core tension was the 'centralisation versus decentralisation' of hospital functions after downsizing and mergers: what was to be done centrally and what regionally, by the hospitals. As shown in Figure 2, centralisation versus decentralisation became the core tension because this tension tends to precede and be a producer rather than a product of the other tensions. We selected 'integrated system versus safety net' and 'downsizing versus maintaining quality' as related tensions because both of these tensions were seen as intermediate steps, with important interrelationships in the 'inpatient futures' effort. The remaining tensions could be deferred because both were consequences of dealing with the others (Figure 2).

Fashioning Strategic Responses

Here we show how to fashion a strategic win–win for the core issue tension. The notion of a 'strategic win–win' draws on ideas found in the conflict management (Thomas, 1976), integrated negotiation (Lewicki & Litterer, 1985), leadership (Covey, 1989), and systems thinking. In our treatment, a strategic win–win must satisfy both concerns that make up an issue tension. Such a strategy creates commitment and support for actions to be taken (Pettigrew, 1987). This occurs because a cooperative culture has been created, disposing of the destructive competitive urges that lie behind most organisa-

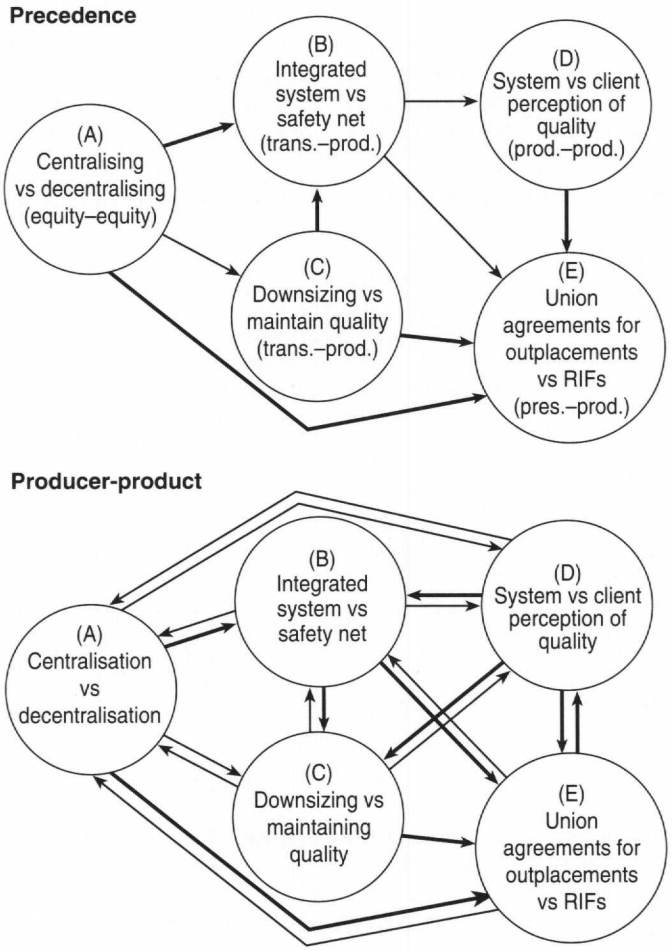

Figure 2. Priority tensions for 'inpatient futures' project.

tional tensions (Pascale, 1990). Win–win strategy assumes that actions provide something of value for all parties with interests.

Proposition 4: finding a win–win strategic action that increases the net payoff to all key stakeholders will improve the prospect of successful strategic change.

Other types of solutions often crop up. A lose–lose arises when people engage in zero-sum games that undermine one another, so both parties lose. A win–lose solution deals with one of the concerns in an issue tension, and ignores the other. Compromise calls for people to negotiate to find an agreement. Both must give up something thought to be useful to resolve their concern to serve the interests in a competing concern.

Covey (1989) claims that compromise has a resource scarcity mentality when a win–win or abundance mentality, in which there is plenty for everyone, leads to better results. For instance, in the labour contract example a productivity-based contract could be negotiated in which productivity

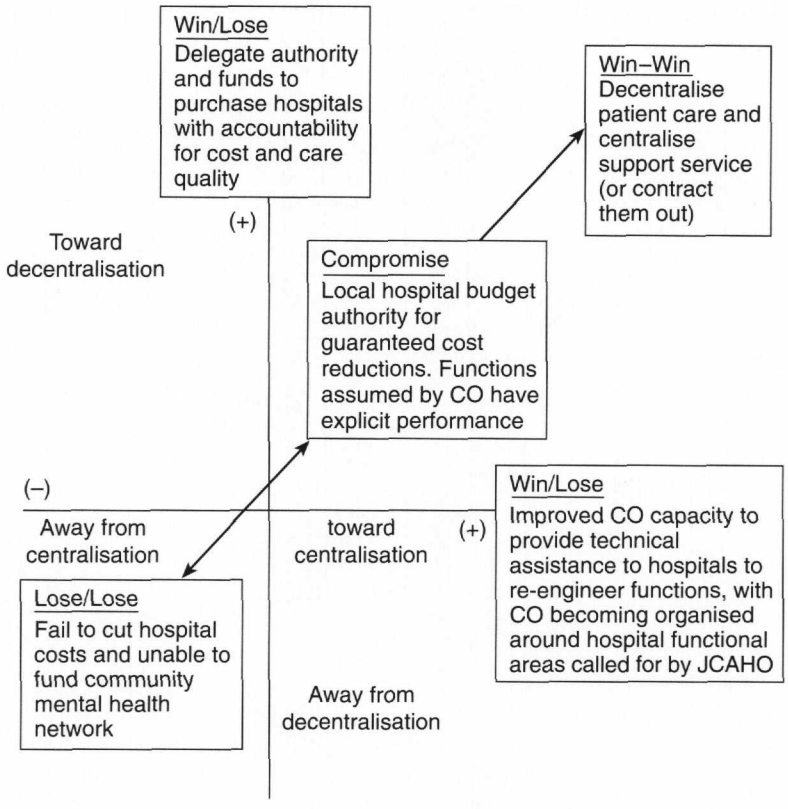

Figure 3. Solutions for the centralisation-decentralisation tension.

increases trigger sharing the cost savings with union members. An abundance mentality does not accept current levels of productivity as a constraint. The challenge is to create a situation in which a strategic win–win can be sought.

An issue tension is represented by the map shown in Figure 3 (e.g. Hampden-Turner, 1981, 1990). Each axis of the map represents one of the concerns that makes up the issue tension. The strategic solution space is filled with lose–lose (down the diagonal), win–lose (at each axis), compromise (at the midpoint), and win–win (up the diagonal, upper right). Using the map, a series of moves are made to work towards a strategic win–win.

Proposition 5: identifying lose–lose, win–lose, and compromises strategy before seeking a win-win strategy improves the prospects of successful strategic change.

We begin by calling attention to lose–lose, or what can happen if the core tension is ignored or left unmanaged (see Table 2). This step motivates action. The next move is to create a win–lose strategy for each concern that makes up the tension. This step helps group members to work out the interests of the key stakeholders in concrete terms. Next, we look for a compromise. This step promotes the notion of working together. To sanction searching for a strategic win–win, we ask the group if they are willing to invest some additional time looking for a better strategic solution—one that

increases the net payoff to all of the stakeholders. The prospect of increasing net payoff is usually sufficiently seductive to get the group to authorise further effort.

The outcome for the 'inpatient future' project is shown in Figure 3. The core tension to be managed was the centralisation versus decentralisation of essential hospital functions. The lose–lose outcome brought with it the prospect of sanctions. Severe budget cuts were apt to be realised if community funding was not available because hospitals did not close. Local rebellion, focused through legislators representing these areas, could have devastating consequences for the ODMH because legislative mandates to trim money were met only in part.

The win–lose solutions to centralisation called for improved central office capacity to provide technical assistance that could benchmark how hospitals best do things. Such an approach was thought to suggest a central office reorganisation around hospital functions called for by accreditation standards. The other win–lose solutions called for a delegation of authority to purchase needed services to the local level, with clear performance expectations (e.g. cost, quality of care). Central office would allocate funds currently being used for support to viable local hospitals. The local hospitals could buy services from the ODMH central office or from others, as needed.

The compromise solution had local hospitals getting increased budget responsibility by guaranteeing a 2% reduction in cost per day per bed. For each function assumed by central office (e.g. medical records) an agreed upon turnaround time and performance expectations were to be set. Hospitals also asked for more clinical education in exchange for some loss in local autonomy. This third compromise was rejected because it was thought to increase costs in the short run, and possibly also in the long run.

A strategic win–win was created that called for a 'redesign' in which both parties were asked to do what they could do best. Hospitals were to be delegated patient care authority and accountability. Central office agreed to provide all support services or contract them out, whichever proved to be the most cost effective. Note how the net payoff to ODMH was increased by assuming an abundance mentality and avoiding compromise solutions.

The process we used to create the win–win strategy in Figure 3 has four steps. The steps call for a facilitator to move up the diagonal in Figure 3, create a bigger space that allows for more possibilities, carry out context reversal, and explore the space with a key group, such as an inner circle.

Move up the Diagonal

Moves that go too far from the diagonal in Figure 3 often cause an organisation to 'get stuck.' One power centre gets favoured and interest groups square off—one to protect further erosion, the other to get more consideration. As a result, a facilitator should move away from a lose–lose and towards a win–win strategy in small steps. In the ODMH project, focusing on problems in hospitals enticed stakeholders to fixate on the 'injustices' visited on the hospitals by cutbacks and a call to spread the misery (see Figure 3). An emphasis on central office ignored the very real problems of hospitals and their distinctive competencies.

The inner circle was divided into two sub-groups to create win–lose

options. People with sympathies or commitments to hospitals (e.g. the hospital CEOs) were placed in the sub-group to deal with the decentralised pull of the core tension. The outer circle members were also divided along their apparent loyalties and asked to join one of the two groups, participating as described previously.

During the generation of each proposed action, sub-group members also listed facts, assumptions, and valued outcomes associated with each action. The fact set was summarised in the presentation to the other group to demonstrate the basis each sub-group used to form its recommendations. For example, facts behind centralisation proposed actions that included: central office budget control, hospitals must cut 500 people, hospitals $10 million underfunded with current client load, and friction between central office and hospitals and the local communities. Facts behind the decentralised proposed actions included: hospital uniqueness (size, scope of service), local autonomy required by some hospital boards, competence in clinical practice, and responsiveness to local systems of care and needs.

The assumptions behind each action were listed to identify beliefs held by each sub-group. The assumptions were open to challenge by members of the other sub-group during presentations. The assumptions cited by the centralisation sub-group included: central office makes inconsistent decisions, hospitals lack timely information from central office, central office must balance hospital and community needs, and some hospitals are unaware of their need to radically change. The decentralisation sub-group assumed that hospitals must respond to local community needs, that political realities call for local decision making, and that little interactions between hospitals were needed. The fact and assumption lists were pooled to indicate areas of agreement and contention to set the stage for the development of compromise strategy. (In some cases, it is desirable to test the assumptions to find those that are both important and certain; Mason & Mitroff (1981). Actions linked to assumptions that fail to meet these requirements would have questionable value. Sub-groups could explore an action set in this way before presenting it to the other group.)

The two sub-groups reported their suggestions to the other, with outer circle listening. To promote compromise, each sub-group met again after their presentations to consider how they could realise their priority actions. Each sub-group member made a list of what they would have to give up to realise each of their recommended priority actions. The list of 'give up' to 'get' actions was then prioritised to identify compromises that each sub-group was willing to make. The two sub-groups then reported their proposed compromises. The top-priority proposed actions from each group became the compromise strategy (see Figure 3).

Enlarge the Arena

Constraints often emerge during problem solving, which narrows the scope of search (Guilford, 1967; Delbecq, 1977; Warfield, 1990).

Proposition 6: a strategy search with minimal constraints produces the best prospects for successful strategic change.

A laddering technique was used to enlarge the arena in which the search for strategy was to be conducted (Nadler, 1981; Nutt, 1992). The valued outcomes identified by the sub-groups were used to form the ladder. The centralised group identified *values* of improved central office (CO) performance, clear CO responsibilities, reduced CO administrative overhead, increase hospital responsiveness to client needs, and support of hospital functions as given by JCAOH accreditation requirements. The decentralised group uncovered *values* of reducing CO costs, strengthening community system of care, enhancing hospital's ability to collaboratively compete, clarifying CO responsiveness to hospitals, and increasing (hospital) income for hospital budgets. These values were used to fashion the ladder. First, the most basic valued outcome is identified. The ladder is then built by adding larger scale valued outcomes in small increments.

A review of the valued outcomes suggests that the most basic was to 'support hospital functions'. To construct the ladder, the facilitator asks the purpose of the lowest scope valued outcome. Why support hospital functions? An answer is to clarify CO responsibility to hospitals. The same type of question is posed again: why clarify responsibilities? An answer was to improve CO performance. By continuing in this way, a hierarchy for the ladder was created, which moves from the least to most inclusive valued outcome as shown in Figure 4. Valued outcomes dealing with the same types of expectations were combined at an appropriate ladder rung. For example, cost and overhead called for similar outcomes, so they were combined.

The ladder poses why and how questions. Moving up the hierarchy answers the *why* question (increases in hospital budget enhance service provision). Moving down the hierarchy poses the *how* question (improved performance reduces overhead). ODMH could increase hospital responsiveness by strengthening the system of care (why) and strengthens the system of care through hospital responsiveness (how), and so on. By moving

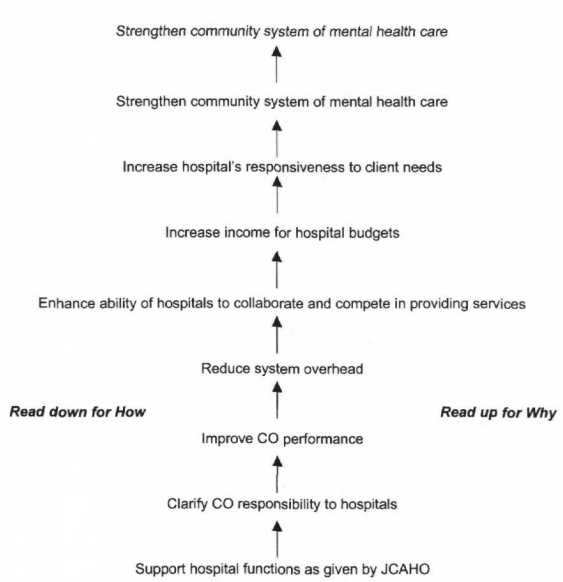

Figure 4. Valued outcome ladder.

up the hierarchy in this way, stakeholders can be shown progressively larger spaces in which strategic solutions can be sought. The bigger space is better because it has fewer constraints (Rothenburg, 1979). The ladder is used to encourage broadening the scope of a search, opening up the search process to more possibilities (Nadler & Hibino, 1990).

The inner and outer circle members voted to select the valued outcome that would guide their efforts to select a win–win strategy. After differences were reconciled through discussion, 'enhancing hospital's ability to provide services' was selected (see Figure 4).

Context Reversal

To guide the search for a win–win strategy, concerns that make up the core tension are reversed by subordinating each pull in the tension to the other (see Table 1).

Proposition 7: context reversal helps to uncover innovative possibilities for win–win strategy that improves the prospect of successful strategic change.

To illustrate this, consider an equity–transition tension. In this case, search would be directed to find transition possibilities in the equity concerns of key people and equity concerns in the transition possibilities being considered. In the 'inpatient futures' project, search sought ways to increase decentralisation as centralisation was carried out and ways to centralise as decentralisation was realised. A win–win strategy embraces both pulls in this tension. This reverses figure and ground, following problem-solving suggestions found in Gestalt psychology (Maier, 1970; Guilford, 1967), so people can see new possibilities.

The inner circle was asked to 'hold the tension' as they searched from win–win ideas. Search was guided by looking for centralised actions that affirmed decentralised values (e.g. autonomy and practice skills) and decentralised actions that affirmed centralised values (e.g. legislative mandate to cut cost and become community based). Listing by the inner circle members was assisted by beginning with a centralised action and then adding decentralised values, moving then to a decentralised action and adding centralised values. Switching back and forth in this way maintained both values as priorities during search, and helped group members hold the tension.

The Integration of Strategic Actions

Strategic actions must fit together to create a succession of action steps that, when carried out, deal with key issue tensions. The win–win strategy must be enhanced by these actions. In addition, these actions must connect to and deal with issue tensions that have interdependent relationships.

Proposition 8: integrated actions that respond to pulls found in the related issue tensions and contribute to the win–win strategy increase the prospects of successful strategic change.

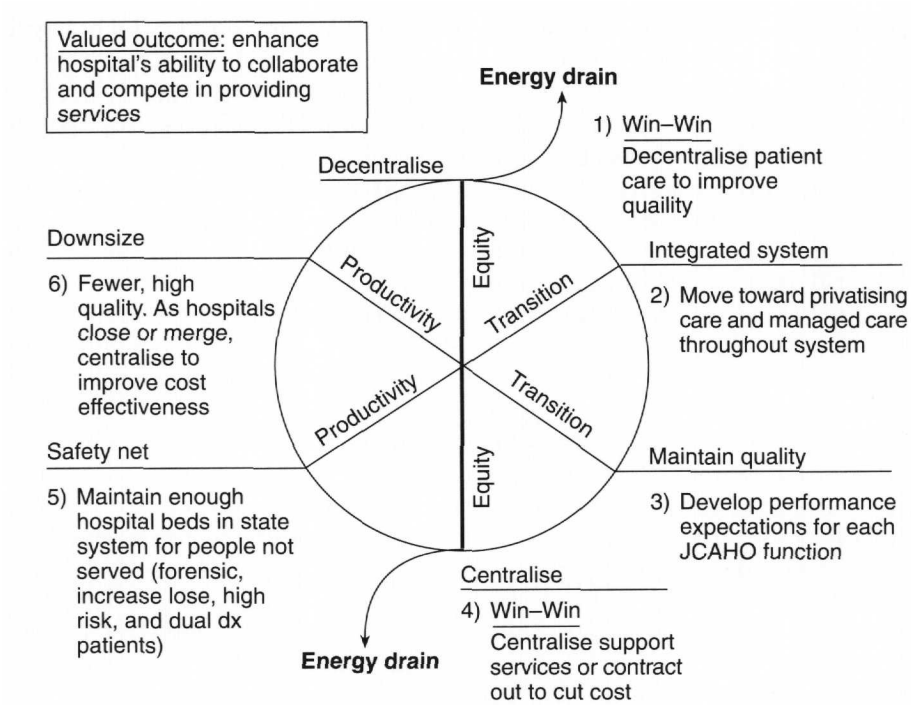

Figure 5. The change circle.

A 'spoke and wheel' configuration shown in Figure 5 offers a way to picture the change logic. First, the priority issue tension or core tension is located on the wheel as a spoke. Other issue tensions that have interdependent relationships (the related tensions) are also arranged as spokes. The win–win strategy is located next to one of the two concerns that make up the priority issue tension. The wheel is circled to search for actions that close the circle. An inductive search for strategic actions that are mutually supportive is carried out. By circling the wheel, the win–win strategy coupled with the other solutions will deal with each issue tension in the wheel.

Propositions 9: several trips around the change circle must be completed before the prospects of successful strategic change begin to improve.

Creating a Strategic Change Circle

To create a strategic change circle, two principles known as intervention and amplification are used (see Table 2). A win–win strategy for the core issue tension provides an *intervention*. The *amplification* principle examines the other key issue tensions and looks for actions that deal with the adjacent concern of the next issue tension that can help to realise the win–win strategy.

Figure 5 summarises the results obtained in the 'inpatient futures' project. The core tension was equity–equity, how ODMH would share the burden of cost cutting. The related issue tensions both involved transition–productivity:

integrated system versus safety net and downsizing versus maintaining quality. The point of intervention is given by the win–win strategy. For the 'inpatient futures' project, the components of the win–win strategy are put on the wheel next to the appropriate pull of the core tension. To amplify, the inner circle members looked for actions that build on the win–win strategy and respond to the pull in the adjacent issue tension. For example, action 1 calls for a decentralisation of patient care to improve quality, holding the hospitals accountable for quality care. The action deals with ODMH's needs to decentralise while maintaining centralised values. Action 2 moves towards privatising care while maintaining quality. The hospitals would be integrated with a specific set of community mental health centres to provide care, preserving the skills and competencies in each hospital that were needed. This action maintains safety net values to ensure that people's needs will be met. Action 3 calls for the development of performance expectations for each accreditation function. Performance assessed in this way could serve as a basis to close and merge hospitals during downsizing. Action 5 provides a safety net by identifying the number of beds required to meet the needs of underserved or unserved clients (clients that are forensic or court ordered, long length of stay, high risk, or dual diagnosis). The limits to integration crops up because these patients often lack health care coverage which keeps them out of private hospitals. Action 6 commits to fewer, higher quality hospitals, centralising funds and activities as closures and mergers take place.

The actions supporting the win–win strategy dealing with related tensions were devised by a group comprising inner and outer circle volunteers. The group was asked to list actions that could realise the valued outcome, enhance the win–win strategy, and deal with each pull in the related tensions. To help in the listing, each person was asked to work around the wheel, starting with action 2 (integrate) then affirm the other pull safety net in action 5, move to action 3 (maintain quality), and affirm the other pull (downsize) in action 6. The actions were then tested to be sure that they would complement the others, fine tuning them as needed. To generate the next set of actions, group members emphasised the tension pull subordinated in the last set, moving back and forth in this way and testing each set of proposed actions for integration before moving on.

In a strategic circle of change, a win–win strategy is amplified by each trip around the wheel, as shown in Figure 5. After several trips, actions begin to transcend the issue tensions that make up the spokes of the wheel. For example, in the 'inpatient futures' project, cycling the patient care decentralisation, privatisation, performance expectations, centralising support services, safety net bed selection, and close and merge hospitals realises the ODMH's valued outcome of enhancing hospitals' ability to provide services. Several cycles must be completed in which these actions are carried out before the issue tensions will be managed.

A strategic change circle produces a desirable outcome when all parties receive something of value. This can be assessed by asking participants about their perceptions or by examining the strategic actions contained in the circle. For instance, in the 'inpatient futures' project, the hospitals and central office stakeholders had clashed over how massive cost cutting was to be carried out. The win–win strategy allowed hospitals to emphasise what they

were best equipped to do, care provision, with fewer central office constraints and surrender support service provision (e.g. human resources, MIS) to central office for re-engineering. A desirable outcome for each interest group was created that reduced conflict. Perhaps the most important indicator of value stems from ODMH's use of the plan. The strategic actions in Figure 5 provided a basis for joint central office–hospital action that lead to realising legislative mandates.

Strategic Change Circle Maintenance

After a number of trips around the wheel in Figure 5, energy losses begin to occur (Maruyama, 1983).

Proposition 10: energy drains in a change circle will reduce the prospect of a successful strategic change.

Strategic change can lose momentum through ill-advised actions by higher-ups, the lack of feedback, and unfocused activity. Momentum losses occur when an issue tension recurs, as shown by arrows that draw energy outwards from the core tension in Figure 5. *Blocking* arises when someone, wittingly or unwittingly, takes action that has a dampening effect on the strategic change cycle, producing an energy drain. For instance, ever-increasing demands by ODMH management for hospitals to account for their actions could create an undercurrent of distrust that can unravel synergistic relationships. *Feedback failures* can also cause an energy drain. For instance, failing to recognise the accomplishments of hospitals or undervaluing their distinctive skills in treatment would suggest that hospital competency was not valued (Kouzes & Posner, 1987). Many *unfocused projects* will fritter away the time of a team with too much unfocused activity. Start-up time becomes excessive, making specific accomplishments more difficult to realise.

Fine Tuning

Even the best-oiled change circle will gradually run down. Entropy arises when people gradually lose their zeal, potentials for strategic change are depleted, and new strategic issues draw away attention. For example, in the 'inpatient futures' project, should the target reduction of $70 million not be reached after several trips around the strategy wheel, new issues may emerge. These issues could involve preserving hospitals with distinctive competencies facing the budget axe or finding ways to provide a safety net for types of clients found to be outside the care system.

Proposition 11: fine tuning actions in a strategic change circle will increase the prospects of continuing to realise the benefits of strategic change.

To maintain the strategic circle of action in a cybernetic loop, a facilitator looks for negative synergy that slows the energy flow and seeks ways to restore or enhance the amplifying actions (Quinn & Cameron, 1988; Smith, 1989). For example, in the 'inpatient futures' project, renewed efforts to cut the cost of support services or to get reimbursement for services rendered

may be able to infuse needed resources. Periodically fine tuning the strategic change circle in this way can keep the change circle operating smoothly for a period of time.

Alignment

In most organisations, more than one strategic change circle will be required to deal with key strategic issues in an issue agenda. This calls for several strategic change circles to be built to deal with bundles of issue tensions that seem important.

Proposition 12: aligning the actions called for across strategic change circles will increase the prospect of organisational success.

Leaders must align the actions called for in each strategic change circle (Thompson, 1967). Strategic actions are integrated across several strategic change circles to create amplification among the circles. For example, actions that limit privatisation of mental health care in another change circle would be investigated to eliminate this inter-circle energy drain. Also, ways to promote inter-circle change amplification can be sought. The co-alignment of an amplifying set of strategic actions provides a powerful engine of strategic change.

Reflecting on the Field Test

To uncover the initial state of affairs, we asked ODMH stakeholders to tell us their view of the 'inpatient futures' project (where we are now), key issues, and what actions they believe should be taken. From an analysis of these data we found a number of pathologies that often plague organisations seeking massive change and just a 'hospital chain' idea, to guide action taking. We selected some typical responses and listed them in Table 1. Under each response a characterisation is offered. One type of response suggests that solutions were displacing issues. An adaptation of a 'hospital chain model' was suggested as both an issue and a strategy by several key people. Ambiguity and uncertainty plagued others who claimed that they did not understand the questions. Such passive-aggressive behaviour often crops up during major change efforts. Other alienated players responded by rejecting the need to act. Behind this claim was alienation over their lack of input and the fear of central office takeover. Others took a 'fact orientation', reeling off numbers to support the need to act. People rarely respond to urgency couched in these terms, as the historically slow progress in the 'inpatient futures' project demonstrated. Rationalists noted the lack of a clear plan, the need for specifics, as well as the absence of ideas about formulation and implementation. Do we have an adequate plan and will their be ownership were common concerns. Other individuals abhorred the disconnected action taken to date and voiced the need for coordinated action, but had no ideas. Coordinators often want collectivism, which is useful, but look to others to provide ideas. Reformers and zealots were also in evidence calling for sweeping change or 'my plan', respectively. The actions initially recommended were based on a call to adapt a single idea: 'the hospital chain'.

Although widely discussed, most people had only a vague understanding of what a hospital chain called for. Others saw it as a 'one size fits all' and worried about the need for flexibility as care treatment models were imposed on the surviving hospitals. This suggests that there was little basis to take action when the 'inpatient futures' project began. We found that our process created reasons to act and mobilised people to take action.

An action plan, rooted in the values of the department, helped key players experiencing a field–headquarters type of tension to find common ground for action taking. This was done by dealing with the core tension involving equity concerns and then exploring tensions arising from integration versus safety net and quality versus downsizing. The 'who gets what' barrier to action that prompted the 'equity–equity' core tension was managed by dealing with the concerns that make up this tension. This provided ownership and a basis for action, which grew from solutions to the two transition–productivity tensions. Without our process, these implicit transition–productivity concerns would have guided the effort. This had failed to prompt action in the past because the pulls between transition and productivity were not understood and because the core tension that was holding the organisation back was left unmanaged. Once a win–win strategy for the core tension was uncovered, participants were able to find ways to deal with the related tensions.

Conclusions

The field test indicates to us that organisations can prepare for large-scale change by using the ideas presented in this paper. Their contribution can be appreciated by comparing the initial state of affairs, noted in Table 1, to the integrated strategy presented in Figure 5. This experience suggests that leaders who undertake an effort that asks the hard questions necessary to fashion strategic issue tensions, uncover win–win strategy for the core tension, and create strategic changes cycles are more apt to be successful. Success stems from the attraction of a change that is challenging, but reachable, and energy releasing, which encourages people to find ways to become involved. The strategic change logic also provides leaders with a way to involve key people in the change process and benefit from their ideas.

Several important questions were not resolved, including the influence of leadership and the difficulty of learning how to apply our concepts. Superior leaders may be able to produce these results without our process ideas. Inferior ones may not be able to make sweeping changes because they do not have and cannot learn a complex process, such as the one we present here. More work is needed to explore this and to refine our process ideas by adding insights into what works and why. One way to do this is to shift our attention from the normative testing of our ideas to a descriptive study of successful leaders. Our current research involves a longitudinal study of change in the Ohio Department of Mental Health. To carry out our study, we have interviewed the leader of ODMH monthly for the past eight years, as well as collected his monthly reports to the governor and major speeches to the legislature and other documents. We plan to continue this and to use the data to study how a leader mounts and maintains radical change over

time. We hope to document shifts in the leader's attention that prompts issues to emerge, the strategic responses that the issues evoke, and their alignment. The study will identify how issues come and go, recycle, and get reframed as tensions by a leader who sees radical change as we do. This will allow us to explore the unfolding issue–strategy link to see how strategy is formed and aligned across issues. This should permit us to examine the role of timing and pacing, how prospective sense making is used to project the events and insights that trigger win–win strategy and their feasibility, and the dynamics of issues and strategies as they influence each other. The insight we gain will be used to refine and extend our process ideas.

Note

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