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Doctoral Thesis

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A practice perspective on the relationship between strategy legitimacy and strategy commitment in umbrella contexts

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ABSTRACT

This research examines the relationship between legitimacy and commitment from a strategy-as-practice perspective. It questions the normative view within the strategy literature which suggests there is a reciprocal relationship between legitimacy and commitment during strategic change i.e. gaining legitimacy for change secures actor's commitment towards it, or where commitment is gained, this infers legitimacy to the strategy.

The central argument is that the strategy legitimacy-commitment relationship may be more complex than the normative view suggests when this relationship is examined from the middle of the organization, and proposes that middle managers face a dilemma as strategists: 'is this the right thing to do?' and 'will I go along with it?'

A longitudinal case study is presented with qualitative data collected in real-time around the development and implementation of an umbrella strategy, whereby "the broad outline is deliberate, while the finer details are allowed to emerge en route" (Mintzberg & Waters, 1985: p263).

The contribution of this thesis is three-fold. First, it shows when strategy legitimacy and commitment are analyzed as multi-variant constructs, they produce multiple types of relationships that are not exclusively reciprocal, but are temporal and shift over time. Second, it illustrates that the type of approach a firm adopts to manage strategic change (e.g. an umbrella strategy) influences middle manager's practices, which subsequently impact on change outcomes in different ways. Third, it offers a contribution to the portraiture of the strategy practitioner, and presents middle managers as reflective strategists who are acutely aware of their scope for exercising managerial agency under umbrella conditions.

This research raises questions about how firms balance generality over specificity when adopting deliberately-emergent approaches, how they reconcile differences between strategists' from plural institutions, manage discretionary practices, and whether guidance should be offered on simultanously managing legitimacy and commitment when evaluations are prone to fluctuation.

INTRODUCTION

Strategic change is often recognized as difficult and unpredictable (Bartunek et al, 2006; Calori et al, 2000; Eden & Ackermann, 1998; Jarzabkowski, 2005; Pettigrew et al, 1992; Van de Ven & Poole, 2005; Vila & Canales, 2008), where intended strategies often lead to unanticipated outcomes (Balogun & Johnson, 1998, 2005; Mintzberg & Waters, 1985; McKinley & Scherer, 2000). Broad theoretical reviews of the strategy literature have shown that the area of strategy implementation is the least researched (Chebat, 1999; Furrer et al, 2008; Mintzberg, 1994, 2007; Mintzberg et al., 2009; Noble, 1999; Vicente-Lorente & Zuniga-Vicente, 2006), where practitioners continue to look for answers to the problems associated with strategic change (Das, 2003; Johnson et al, 2003; Meyer & Allen, 1997; Miller et al, 2004; Tranfield & Starkey, 1998).

The dominant approach within the research community that has chosen to focus on implementation has been normative. The common outcome of this work has tended to focus upon producing prescriptive models of implementation (Andrews, 1987; Carroll & Flood, 2000; Guth & MacMillan, 1986; Hrebiniak, 2006; Kaplan & Norton, 1992, 1996, 2004; Nutt et al, 2000; Radnor, 2010). Despite the development of these models, which serve as practical strategy tools, their explanatory value is limited as they fail to account for what practices shape the outcome of strategic change.

As a means of influencing change outcomes, the strategy literature describes the aspiration of top management to attain actor's commitment to managerial espoused change targets (Balogun & Hope-Hailey, 2004; Johnson et al, 2008; Mantere & Vaara, 2008). Indeed, many researchers encourage and advocate that top management foster legitimacy for strategic decisions to secure actor's commitment towards the development and implementation of an intended strategy (Ackermann & Eden, 2005; Barney, 1991; Beer et al, 1990; Brown, 1998; Dess & Priem, 1995; Dooley & Fryxell, 1999; Eden & Ackerman, 1998; Lines, 2007; Quinn, 1980; Tyler & Blader, 2005). Therefore, where legitimacy is gained, this creates commitment to the strategy.

Researchers have also argued that where commitment is gained, this infers legitimacy for the strategy (Brown, 1998; Dooley et al, 2000; Human & Provan, 2000; Nutt et al, 2000; Pfeffer, 1981; Stone & Brush, 1996). The normative view suggests there is a reciprocal relationship between gaining legitimacy and attaining actor's commitment within the strategy process which will, in turn, support successful strategic change.

However, a framework which integrates the wider strategy, legitimacy, and commitment discourses to support this assertion of reciprocity has so far not been developed in the strategic change literature. Furthermore, little research exists at the micro level of analysis which draws upon the narratives of those outside of top management teams whose legitimacy and commitment is being sought. Namely, how middle managers confer legitimacy to strategic decisions (Laine & Vaara, 2007), and how they develop the commitment sought by top management to put those decisions into action (Hbreniak, 2006; Mantere, 2007).

The purpose of this study is three-fold.

First, it aims to develop a framework that integrates strategy, legitimacy, and commitment research to better understand the strategy legitimacy-commitment ('L-C') relationship during strategic change from the perspectives of those outside of top management teams. The framework will then be applied to examine whether the relationship is always reciprocal.

It will examine middle managers' evaluations of the legitimacy of the strategy content and process (Regner, 2003; Suchman, 1995), and to explore the *basis* of their commitment towards it (O'Reilly & Chatman, 1986). The thinking, discursive, and behavioural practices which middle managers draw upon to confer legitimacy, and commit to, strategy goals are the primary focus of analysis (Balogun, 2003; Barry & Elmes, 1997; Johnson et al, 2007; Rouleau, 2005; Salancik, 1977; Weick, 1995).

Second, this study sets out to examine whether umbrella strategy conditions (Mintzberg & Waters, 1985) play a role in shaping middle managers strategy legitimacy and commitment evaluations, and to what extent these conditions influence their reasoning and strategizing activities (Regner, 2003).

Umbrella strategies are described as 'deliberately-emergent' where "the broad outlines are deliberate, while the finer details are allowed to emerge en route" (Mintzberg & Waters, 1985: p263). Top management have only partial control over other actors in an organization, but set general guidelines for behaviour by defining boundaries, and then let other actors manoeuvre within them. Strategies are allowed to emerge within these boundaries, and this allows actors some degree of autonomy and discretion to influence the emergent aspects of the process, even though the general direction of the strategy has initially been pre-determined and broadly defined by central top management through formal planning.

Mintzberg & Waters (1985) summarise the essence of an umbrella strategy as "defining general direction subject to varied interpretation" (p263).

In prioritizing the strategy-as-practice perspective (Johnson et al, 2007), it is argued that it is important to examine how middle managers strategize under umbrella conditions as they arguably characterize much "contemporary strategizing" (Mantere & Vaara, 2008: p353). Namely, those types of strategies which combine both top-down and bottom-up processes (Brown & Humphreys, 2003; Laine & Vaara, 2007; Quinn, 1980; Westley, 1990).

Vila & Canales (2008) have suggested that such approaches to strategic management which balance planning and emergent elements are somehow unique, novel, or "radical" (p2). However, Mintzberg & Water's (1985) have long argued, "Virtually all real-world strategies have umbrella characteristics....as in no organization can the central leadership totally pre-empt the discretion of others, and in none does a central leadership defer totally to others" (p263). Similarly, Johnson et al (2008) have highlighted how umbrella approaches fit the descriptions that managers themselves give of how strategies are managed in their organizations (p409-410).

In spite of these debates over the pervasiveness of deliberately-emergent approaches to strategic management in modern organizations, little remains known about the type of middle manager practices which accompany umbrella strategies.

The importance of examining the broader contextual factors associated with strategic change has been strongly emphasized by practice researchers (Balogun, 2006; Melin, 1989; Rouleau et al, 2007; Whittington, 2006). Moreover, this message has been echoed within legitimacy and commitment fields. For example, management researchers have been encouraged to consider whether particular environmental conditions are distinctively congenial to certain types of legitimacy (Suchman, 1995), and the environmental conditions which can create commitment have long been highlighted as an important factor in the organizational commitment literature in researchers' attempts to identify antecedents of commitment to 'the organization' (Mathieu & Zajac, 1990; Meyer & Allen, 1997).

Umbrella conditions are also interesting strategic contexts to examine from a strategy-as-practice perspective because they provide considerable potential for groups or individual strategists to enter into the process and determine, or distort, the strategy if the legitimacy of its content or process is questioned (Mantere, 2007; Mintzberg et al, 2009).

Mintzberg & Water's (1985) state that "those who have the vision do not control its realization: instead they must convince others to pursue it" (p263). As top management operate without complete control over the realization of the strategy, justifying to actors its merits (Fiss & Zajac, 2006), and seeking middle management commitment towards its development (Wooldridge & Floyd, 1990), all become critical to its implementation.

In such circumstances, top managers may construct "a collective approach" to strategizing (Laine & Vaara, 2007: p46), that involves deliberate planning while also attempting to "convince others" to pursue a new direction (Mintzberg & Waters, 1985: p263) by co-opting them into the strategy development process (Quinn, 1980; Meyer & Rowan, 1991; Selznick, 1949; Suchman, 1995). The simultaneous use of 'edicts' and 'participation' (Nutt, 1986, 1987, 1989, 1998, 1999) typifies the implementation tactics deployed by top management in umbrella strategies (Quinn, 1980).

The co-opting process associated with umbrella approaches also implies that those outside of top management teams can be considered 'strategists' (Jarzabkowski et al, 2007), as the design and development role is awarded to middle managers, albeit their strategic involvement is primarily 'along the way' or 'en route'. But when middle managers are co-opted into the development of an umbrella strategy process in this way, the scope of their responsibilities becomes wider, and their level of authority and autonomy increases as power becomes diffused (Giddens, 1979; Whittington, 1992).

This enables middle managers to have a significant influence on developing the finer details of an umbrella strategy for those goals that are ambiguous to the extent that they leave considerable room for interpretation (Mintzberg & Waters, 1985). In doing so, this type of approach would appear to provide opportunities for acts of managerial agency (Campbell-Hunt, 2007; Mantere, 2007).

Furthermore, it is possible for a discrepancy to emerge between the 'broad principles' or explicitly-stated espoused change targets prescribed in the deliberate outlined aspects of the umbrella strategy, and the emergent practices which middle managers employ as they 'work on the finer details' whilst they go along to achieve these targets. There lies the potential for these to come into conflict.

The details or activities that are required to support the broad principles of the strategy may be discordant or lack the approval of middle managers (Floyd & Lane, 2000). Although the

broad strategy principles may be supported, the activities that are necessary for their execution may not be developed or implemented, especially if middle managers are aware of their scope to manoeuvre that an umbrella strategy arguably allow them (Bourdeau, 1990; Jarzabkowski, 2005; Laine & Vaara, 2007; Mantere, 2007).

For example, Suchman (1995) has argued that the altruistic grounding of 'moral legitimacy' is not entirely interest-free (p579), which suggests that even when actors judge an activity (i.e. strategic activity) as doing 'the right thing', they also hold the capacity and volition to consider whether to fully engage or commit to the process of performing that activity. While Giangreco & Peccei (2005) have suggested that open and uninhibited resistance to change is not a feasible option for middle managers and they tend to express their indifference in less overt ways.

However, it remains unexplained what middle managers do in situations where they also hold a recognized strategist role (Jarzabkowski et al, 2007), and how they reconcile themselves to developing activities which requires them to promote strategy goals that conflict with their own personal or professional values, and which may have consequences for themselves individually, their professional group, and their organization (Turnbull, 2001). This thesis proposes that under umbrella conditions, middle managers may face a dilemma in legitimacy-commitment terms: 'is this the right thing to do?' (I.e. is it legitimate what we are doing?'), and 'will I go along with it?'('I.e. will I commit to what is proposed?').

It is these legitimacy and commitment dimensions of umbrella strategies, and the internal conditions which this type of strategy subsequently creates which are "subject to varied interpretation" (Mintzberg & Waters, 1985: p263), that may help explain strategists' activities and what middle manager's *do* in practice when developing the finer details 'en route', especially where "justification problems" arise (Fiss & Zajac, 2006: p1174) around the need for change and the way in which it is managed (Balogun & Hope-Hailey, 2004; Bartunek et al, 2007).

Third, this study aims to examine how middle managers respond in this strategic context because it may help explain how their emergent practices may be consequential for firm outcomes (Jarzabkowski et al, 2007).

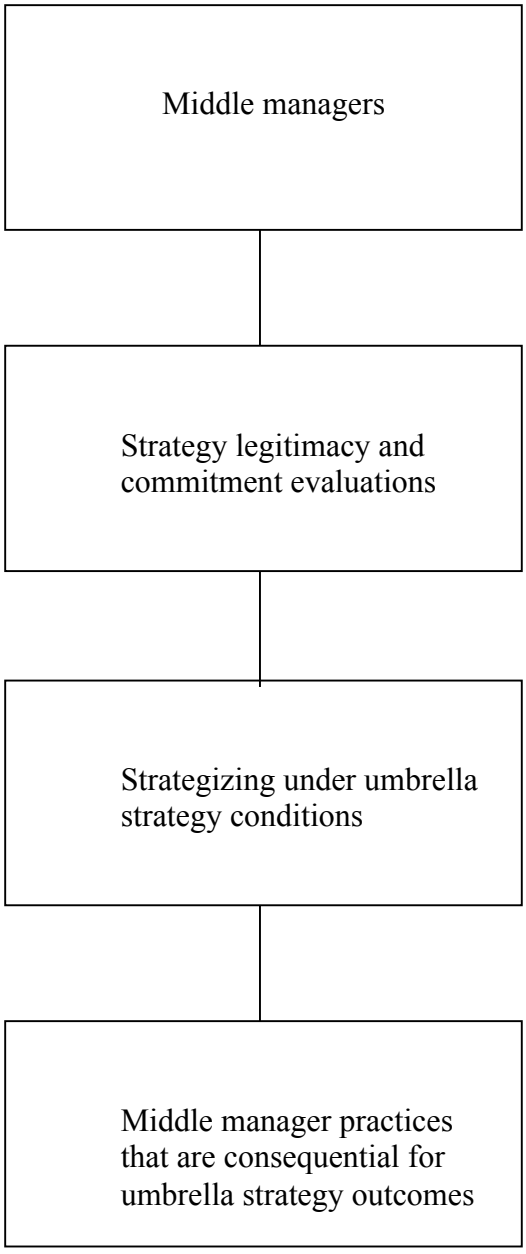
For example, when the operational details of strategic actions are left to middle managers to develop (Mantere, 2007), it allow them to fulfil the promise of being viewed heroically or as

"strategic assets" (Balogun, 2003, p69; Floyd & Wooldridge, 1997). Conversely, it affords them the opportunity to behave "obstructively" and be depicted in a negative light (Connors & Romberg, 1991: p61; Guth & McMillan, 1986; Meyer, 2006). The level of discretion and autonomy, which is created as a consequence of an umbrella approach, potentially leaves middle managers vulnerable to accusations of culpability from top management and lower-level operational workers when strategic change is not unfolding as intended (Balogun, 2003; Sims, 2003). Either way, umbrella conditions place middle manager strategists in a situation where their role, and their practices, may be critical to the outcomes of the strategy process.

It is argued that strategy-as-practice can fill these research gaps for strategy researchers and practitioners by defining the concepts of *strategy legitimacy* and *strategy commitment* in an explicit and unambiguous way (Golsorkhi et al, forthcoming; Johnson et al, 2007), by examining the strategy L-C relationship from a micro-level of analysis, and by drawing upon the narratives of those outside of top management teams (Johnson et al, 2003; Rouleau, 2005).

By taking cognisance of the *strategic context* in which legitimacy and commitment evaluations are conducted (Balogun, 2006; Rouleau et al, 2007), this research will examine how the types of practices which emerge under umbrella conditions may be consequential for firm outcomes (Jarzabkowski et al, 2007; Mintzberg & Waters, 1985) (See Figure 1).

Figure 1 Summarizing the key themes of interest



THESIS STRUCTURE

The purpose of Chapter 1 is to discuss how the strategy-as-practice perspective extends existing perspectives within the strategy field, and how the practice lens offers important research considerations for this thesis.

The purpose of Chapter 2 is to review those problems commonly associated with developing and implementing strategic change. It highlights the emphasis that strategy researchers place on the challenge of gaining legitimacy, and the importance of attaining actor's commitment when managing change. It questions the normative view in the strategy literature which suggests there is a reciprocal relationship between legitimacy and commitment during the strategy process.

The purpose of Chapter 3 is to examine more closely how legitimacy and commitment are conceptualised theoretically and applied empirically across the strategy and management literature, prior to establishing two working definitions for this thesis: 'strategy legitimacy' and 'strategy commitment.' The chapter synthesizes the key points from across the strategy, legitimacy, and commitment fields into the central argument of this thesis, and concludes by presenting three research questions.

Chapter 4 outlines the research design process, including data collections methods, and the analytical process. It presents the case study background and describes the umbrella strategy context involving two public sector organizations who are responsible for delivering integrated drug and alcohol addiction services.

Chapter's 5, 6, and 7 consists of findings from three data collection periods over one year: Time 1 (the start of change at December.03), Time 2 (six months on at May.04), and Time 3 (twelve months on at December.04). Chapter 5 produces findings relating to strategy goal 1 ('developing an exit strategy for methadone service user's'), Chapter 6 focuses on strategy goal 2 ('to ensure that working in Community Addiction Teams is a professionally rewarding experience'), and Chapter 7 focuses on strategy goal 3 ('to provide equitable and improved access to alcohol services'). Each of these three chapters provides first, second, and third-order levels of analysis.

Chapter 8 presents discussion and analysis of the findings, whilst Chapter 9 concludes the thesis by stating its contribution to theory, practice, and its implications for future research.

CHAPTER 1

STRATEGY AND CHANGE

Introduction

The purpose of this chapter is to present the case for studying the phenomena of strategic change from a strategy-as-practice perspective, as it currently remains "a developing field" of strategy research (Balogun et al, 2007: p196). It draws on the strengths and limitations of traditional theoretical conceptualisations of strategic change, including the content and process research traditions, which together, have influenced calls for a new approach to strategy research and have contributed to shaping the central tenets of strategy-as-practice (Jarzabkowski & Spree, 2009; Johnson et al, 2003; Johnson et al, 2007; Whittington, 2006).

The chapter concludes by discussing important research considerations that strategy-as-practice presents for this thesis, namely, the role of those outside of top management teams during strategic change (Balogun & Johnson, 2005), and how these actors' practices require to be understood within their wider social context (Rouleau et al, 2007; Whittington, 2006).

1.1 Theorizing strategic change from a strategy-as-practice perspective

Traditional theoretical conceptualisations of strategy differ in terms of the level of emphasis they each place on exogenous and endogenous factors which influence strategic change (Hatch & Cunliffe, 2006), in addition to their different macro and micro-level orientations (Johnson et al, 2003). Organizational theorists have long debated over why organizations find that they require to change direction (Hannan & Freeman, 1978; Meyer & Rowan, 1977), what external and internal factors influence their decisions to change direction (Burns & Stalker, 1961; Pfeffer & Salancik, 1978), and each have offered a variety of explanations of why organizations adopt a particular course of action (Tsoukas & Knudsen, 2003).

From a strategy-as-practice perspective, organizational theorists have made important contributions to the field of strategic management (Johnson et al, 2007). However, there are elements of strategic change that organizational theorists fail to elaborate upon or explain (Balogun et al, 2007; Westwood & Clegg, 2003).

The main criticisms of traditional theoretical perspectives from a strategy-as-practice standpoint are that they have for too long focused on the macro-level of firm behaviour at the expense of micro-level phenomena (Jarzabkowski et al, 2007; Johnson et al, 2003). This

disparity has raised concerns in terms of strategy research output using some organizational theoretical frames which offer "little evidence of human action" (Jarzabkowski et al, 2007: p6), and where micro-activities are "invisible" (Johnson et al, 2003: p3). There is however elements of institutional (DiMaggio & Powell, 1983; Meyer & Rowan, 1977; Seo & Creed, 2002), structuration (Barley & Tolbert, 1997; Giddens, 1984), and agency (Caldwell, 2006; Jensen & Meckling, 1976) theories which are considered as important theoretical influences for practice research.

For example, strategy-as-practice is concerned with "what people do in relation to strategy and how this is influenced by and influences their *organizational* and *institutional* context" (Johnson et al, 2007: p7). It also stresses the need to explore micro-level activities (Johnson et al, 2003), but highlights the importance of 'contextualizing' micro-activities on the basis that actors are not acting in isolation but are drawing upon the regular, socially-defined modes of acting that arise from the plural social institutions to which they belong (Whittington, 2006). In this sense, strategic actors are not just members of organizations, but part of social groups on whose influences they draw (Whittington, 2006: p628). Principally, micro-phenomena need to be understood in their wider social context.

Practice researchers have also called for greater attention to be given to micro-level processes which underpin and constitute macro-level phenomena (Johnson et al, 2003) and encourages researchers to adopt a 'dual focus' in order to explore the links between micro and macro-perspectives on strategy (Jarzabkowski, 2004; Whittington, 2006). Balogun et al (2007) have suggested that by strategy research re-focusing on practitioners and "bringing the human actor to front stage" examination of the actions and interactions of the strategy practitioner can enable a better understanding of human agency in the construction and enactment of strategy (p196). This reinstatement of agency in strategic action reflects the wider 'practice turn' throughout the social sciences (Reckwitz, 2002; Schatski et al, 2001; Toumlin, 2001) and in management research (Tsoukas & Cummings, 1997; Whittington, 2006), that aims to 're-humanize' management and organization research (Jarzabkowski et al, 2007; Pettigrew et al, 2002; Weick, 1979).

Strategy-as-practice emphasizes the importance of studying the myriad of micro-actions through which human actors shape activity in ways that are consequential for organizational strategic outcomes (Johnson et al, 2003: p3). Hence, greater attention is given to 'strategizing' or 'the doing' of strategy and the construction of the flow of activity through

the actions and interactions of multiple actors and the practices that they draw upon (Jarzabkowski et al, 2007: p8).

Activities that are considered to be 'strategic' are those which are consequential for the strategic outcomes, directions, survival, and competitive advantage of the firm (Johnson et al, 2003), even where those consequences are not part of an intended and formally articulated strategy (Jarzabkowski et al, 2007). This approach has shifted the analytical focus of strategy-as-practice towards "who strategists are, what they do and why, and how that is influential for the practice of strategy" (Balogun et al, 2007: p204) - all of which better reflects the practitioner focus of this thesis.

In summary, studying strategic change through a practice lens offers greater utility to the aims of this thesis, which is to better understand what strategy practitioners *do* during strategic change, instead of adopting a specific theory that informs, or helps explain the process of strategic change. As Jarzabkowski et al (2007) point out, strategy-as-practice is less characterized by what theory is adopted than by what problem is explained (p19).

In addition to organization theories, different perspectives on strategic change have been offered by strategy researchers. There is considerable disagreement within the literature regarding the nature of strategic change and what predominantly characterizes the strategy process. Previous theoretical overviews have categorized these perspectives on strategy as 'schools' of strategic thought (Mintzberg, Ahlstrand & Lampel, 2009), generic strategic perspectives (Whittington, 2001), behaviourist, cognitive and discursive perspectives (Tsoukas, 2004), strategy as types of discursive constructions (Caldwell, 2006; Vaara, Kleymann & Seristo, 2004), strategy lenses (Johnson, Scholes & Whittington, 2008), and strategy as 'journey-making' (Eden & Ackermann, 1998).

Two observations can be noted from this collection of perspectives. For instance, Whittington's (2001) four generic perspectives on strategy tend to overlap with Mintzberg et al's (2009) ten schools of strategic thought, which also overlap with Johnson et al's (2008) three strategy lenses, and so forth. Therefore, some replication is evident across these categorizations. Also, Mintzberg et al (2009) acknowledge that while each of their 'schools' offer something that is "interesting and insightful", they are also prone to being "narrow" and "overstated" (p4). Similarly, Johnson et al (2008) acknowledge no one [strategy] lens presents the full picture.

In sum, a broad, holistic, multi-dimensional view of the strategy process is required as opposed to a one-dimensional view, which reflects recent arguments from strategy-as-practice researchers for the need to take a more integrative view of strategy (Regner, 2003; Whittington, 2006). However, two classifications, albeit broad, do appear to hold up across the collection of perspectives: content and process.

Strategy-as-practice by no means unequivocally dismisses content and process traditions. It is the criticisms of - and to some extent, concordance with - traditional conceptualizations of strategy which shape the theoretical basis of this thesis from a practice perspective. Strategy-as-practice acknowledges the important contributions that both traditions have made to the development of the field, and the insights they have produced for practitioners and academics (Balogun et al, 2007).

Johnson et al (2003) note that the content tradition has presented a number of key issues relating to diversification and restructuring, which strategy-as-practice considers worthy of exploring further (Whittington, 2006), as well as formal strategy work, which remains a resource-consuming activity and is considered to have significant symbolic and social functions beyond its stated intent (Hodgkinson et al, 2005; Langley, 1989; Miller et al, 2004).

However, content research has been criticized by strategy-as-practice researchers because it has confined itself to macro-level analysis, applies crude measures for analysis, presents ambiguous concepts and performance relationships, and excludes action by "obscuring" what managers do in practice (Johnson et al, 2003: p6; Whittington, 2002). Modernist strategy approaches - associated with the classical, design, and positioning schools (Ansoff, 1965; Chandler, 1962; Miles & Snow, 1978; Porter, 1980) – have shown a tendency towards "valuing scientific detachment over practical engagement, the general over the contextual, and the quantitative over the qualitative" (Whittington, 2004: p62).

Content research has also been labelled as "highly abstract" (Johnson et al, 2003: p6), and called "naïve" on the basis that it has failed to determine whether diversification enhances profitability (Grant, 2002: p92), or if there are any real advantages of introducing multidivisional structures which successfully fit with various diversification strategies (Whittington, 2002). Consequently, it is the process tradition that is recognized as offering richer foundations for the field of strategy research from which strategy-as-practice seeks to build upon (Johnson et al, 2007; Laine & Vaara, 2007; Mantere & Vaara, 2008). It is the process tradition that this thesis associates more closely with than content-based approaches.

Strategy-as-practice is "strongly sympathetic" to several aspects of the process tradition (Johnson et al, 2003: p10). It has "humanized" the field of strategy research with human beings (Pettigrew et al, 2002: p12), has closely examined managerial work, and it has asked critical questions about the political, cognitive, and cultural aspects of strategic change which are significant for strategy outcomes (e.g. Mintzberg, 1973; Johnson, 1987; Pettigrew, 1985, 1977).

Process studies have tended to adopt qualitative methods, used smaller-sample sizes, and provided rich in-depth studies to provide the type of insights which the predominantly quantitative-based content tradition have failed to provide (Johnson et al, 2003). Importantly, it has drawn attention to the problems associated with the internal dynamics of the organization in the strategy process, demonstrated the potential to capture micro aspects of strategic actions by filling theoretical constructs with human beings, and has attempted to open up "the black box" of the organization (Johnson et al, 2003: p10).

Yet process studies have been criticized also for their oversensitivity to micro-level managerial activity without fully acknowledging the wider social context in which this activity actually takes place (Johnson et al, 2003; Tsoukas, 1994; Whittington, 2006). It has also been too willing to distance itself from content issues such as diversification and structure (Charvarthy & White, 2002), and has placed too great an emphasis on the emergent aspects of strategy having greater significance than the more formal aspects of the strategy process (Johnson et al, 2003; Whittington, 2004).

From a strategy-as-practice perspective, process studies do not go deep enough into the strategy process in order to explore what practices and activities influence decisions (Brown & Duguid, 2000; Chakravarthy & Doz, 1992). In particular, it has stopped short of going further into the role of managerial agency (Johnson et al, 2003), or focusing more on the roles and activities of those actors on the periphery out-with top management teams (Johnson & Huff, 1997; Regner, 2003; Rouleau, 2005).

But the main problem with the process tradition is that it too often lacks explicit links to strategy outcomes (Chakravarthy & White, 2002). Subsequently, process study insights' "practical usefulness" for managers has been questioned by strategy-as-practice researchers (Johnson et al, 2003: p12).

Common to both content and process research traditions are four issues of debate:

i. strategy as a deliberate or emergent process

ii. formulation and implementation as distinct processes

iii. factors that affect firm performance during strategic change

iv. and the extent to which the strategic change process can be managed

The content tradition has long advocated strategy- making as a deliberate, planned, rational, analytical-based activity, from which logical top-down goals are cascaded down throughout the organization by a series of designed measures (Andrews, 1987; Ansoff, 1965; Chandler, 1982). Content researchers delineate formulation and implementation as discrete, distinct processes which separate conception from execution (Reed & Buckley, 1988; Sloan, 1963), and one of the premises of the content tradition is that it is only after unique and explicit strategies are fully formulated can they be implemented (Mintzberg, 1994; Mintzberg et al, 2009).

The process tradition, on the other hand, conveys a less linear view of the strategy process (Miller, 1982; Mintzberg & Waters, 1985), and instead observes it to be more emergent, complex, and changing at different points in time with varying episodic patterns that have been labelled as 'logical incrementalism' (Quinn, 1980), 'punctuated equilibrium' (Tushman & Romanelli, 1985), and 'strategic drift' (Johnson, 1992). Processualists argue that in practice, formulation and implementation processes overlap and are often interdependent of one another (Hrebiniak, 2006; Mintzberg, 1994).

From a strategy-as-practice perspective, there is a need for researchers to take a more integrative view of strategy by acknowledging the interlinked nature of all content *and* processual components (Balogun et al, 2007; Jarzabkowski, 2005; Whittington, 2004, 2006). Content and process traditions have created 'unnecessary dualisms' (Tsoukas, 2004) and 'false dichotomies' (Balogun et al, 2007), and the separation of formulation and implementation as distinct processes is regarded as generally unhelpful to moving the strategic management field forward (Balogun et al, 2007).

The debate over whether strategy is a deliberate or emergent process is considered to be not so important from a strategy-as-practice perspective (Jarzabkowski, 2005), as distinguishing between steady state processes and processes of change create an "artificial divide" which accommodates theoretical and empirical reductionism (Chakravarthy & White, 2002: p184).

What really matters are the processes and practices that constitute everyday activities of organizational life that relate to strategic outcomes at the level of the firm and the wider environment (Balogun et al, 2007). The consequence of viewing formulation and implementation as less discrete is that a much wider group of actors require to be considered as part of the strategy process (Balogun et al, 2003).

Strategy-as-practice proposes actively 'dismantling' the content and process division which has come to characterize strategy research in recent years (Johnson et al, 2003). Indeed, Regner (2003) has provided empirical support to this process by demonstrating that content and process are interdependent rather than independent subjects, and Vila & Canales (2008) showed how one firm effectively encompassed both planning and emergent elements into their strategy development process.

Both content and process traditions also diverge over those factors which most affect firm performance during strategic change (Barney, 2001; Johnson, 1987; Pettigrew, 1985). Content research is strongly aligned with the planning, design, and positioning schools of strategic thought, (Ansoff, 1965; Christensen et al, 1982; Porter, 1985), where expectations of strategic change are informed by analytical, economic rationality (Rumelt et al, 1994). In contrast, the process tradition focuses more on the political, cognitive, learning, and cultural aspects of the strategy process (Hodgkinson & Sparrow, 2002; Johnson, 1987; Pettigrew, 1985; Reger & Huff, 1993), and place greater emphasis on the importance of organizational context to strategic change (Balogun, 2006; Brown & Dugiud, 2001; Pettigrew & Whipp, 1991; Whittington, 2006).

Process researchers have provided empirical support that strategies can produce intended and unintended outcomes (Balogun, 2006; Balogun & Johnson, 2005; Mintzberg & Waters, 1985; McKinley & Scherer, 2000), and they have raised questions over the extent to which the strategic change process can be managed (Balogun & Johnson, 1998; Harris & Ogbanna, 2002), whereas the content tradition's working assumption has been that "senior managers are rational actors who defined strategies that everyone else embraced, being the compliant and loyal 'human resources' that they were" (Mintzberg et al, 2009: p244).

Strategy-as-practice shares a mutual concern for firm performance with the content tradition (Ambrosini et al, 2007), however, it disputes representing human activity through "a series of causally related variables" which characterizes performance-related studies (Balogun et al, 2007: p196). It is not only the performance of strategists which matters in terms of

understanding how they perform their roles and what their everyday activities involve, but it the understanding of practices being turned to managerial advantage, and how insights can help practitioners understand and improve their practice, which is key from a strategy-as-practice perspective (Whittington, 2004: p64). To achieve this research objective, exploring the detailed or "mundane" micro-level aspects of strategizing is crucial, because these may be potentially linked to strategic outcomes at the firm-level (Balogun et al, 2007: p200).

Strategy-as-practice acknowledges that intended strategies often produce unanticipated outcomes, and the extent to which strategic change-related practices or activities can be managed is a concern for strategy-as-practice (Johnson et al, 2007). The type of "actionable guidance" strategy researchers are providing to managers matters in a practical sense (Johnson et al, 2003: p15), in addition to how sociological understanding can be turned into practical advantage (Whittington, 2004: p63).

Prescriptive models of managing change which have been offered by both content and process traditions (Andrews, 1987; Burnes, 2004; Kotter, 1995; Lewin, 1949; McCalman & Paton, 2008) can arguably be over-simplistic, hyper-rational, idealistic, context-dependent, and create false expectations for managers (Knights & Morgan, 1991; Mintzberg, 1994; Tsoukas, 2005).

The practice view of this issue is that strategy researchers require to give greater consideration to the expectations that their research recommendations set, how their research insights can be useful in a practical sense, and what aspect(s) of humans resources are viewed as being beyond managerial control (Johnson et al, 2003; Priem & Butler, 2001). Indeed, this particular issue can be partly-credited with the emergence of strategy-as-practice within the field of strategy research, because practitioners were critical of traditional strategy research for being 'remote' from managerial practice, as it did not address managers' real strategy problems, or provide support in the form of useful guidelines (Das, 2003; Johnson et al, 2003; Starkey & Madden, 2001).

In response to exclusive content or process-orientated approaches to strategy research, the strategy-as-practice agenda attempts "a fundamental inversion of dominant conceptions of strategy" (Jarzabkowski & Whittington, 2008: p101), not by completely abandoning existing traditions of strategy research, but by extending them (Johnson et al, 2003). Traditional approaches have been inclined to treat strategy as a property of organizations i.e. an organization *has* a strategy of some kind (Whittington, 2006: p613), and the strategy

literature has been dominated by concepts of strategy as a top-down process of formulation separated from implementation, predisposing a focus upon top managers, their demographics, and their decision-making processes (Balogun et al, 2007: p202).

The consequences of such an orientation have been that "strategy research contributions are paradigmatically constrained by the positivistic assumptions and research traditions of micro-economics, which avoid 'the messy realities' of doing strategy" (Balogun et al, 2007: p196). Strategy research is therefore considered by strategy-as-practice researchers to have become too reductionist and limited in its explanation of human activities (Golsorkhi et al, forthcoming).

By re-focusing on practitioners during strategic change, and 'bringing the human actor to front stage', examination of the actions and interactions of the strategy practitioner can enable a better understanding of human agency in the construction and enactment of strategy (Balogun et al, 2007: p196). This reinstatement of agency in strategic action reflects the wider 'practice turn' (Orlikowski, 1992, 2000; Orr, 1996; Schatzki et al, 2001) or 'linguistic turn' (Alvesson & Karreman, 2000; Grant et al, 2003) in the social sciences which regards actors as creative agents who are reflexive, and their social systems open and plural enough, to free their activity from mindless reproduction of initial conditions (Giddens, 1991).

To fulfil this broad research agenda, strategy-as-practice researchers have called for the 're-introduction' of 'the strategist' in strategy research, and for a stronger focus on strategists' 'lived experience' (Samra-Frederick's, 2003) and their everyday activities (Balogun et al, 2007: p196).

Strategy-as-practice proposes a re-evaluation of who can be considered 'a strategist,' as some studies have identified a much wider group of actors such as middle managers and lower-level employees who are important strategic actors (Balogun, 2003; Dutton et al, 2001; Floyd & Lane, 2000; Jarzabkowksi et al, 2007; Mantere, 2007; Rouleau, 2005). In particular, it recognizes the role of those managers on the periphery of organizations in addition to those in top management teams at the centre (Johnson & Huff, 1997; Reger, 2003), and calls for a better understanding of strategic change outcomes may lie in those managers' micro-activities (Johnson et al, 2003), which can take the form of their mental activities, talk, and motivations (Melin, 2007; Reckwitz, 2002).

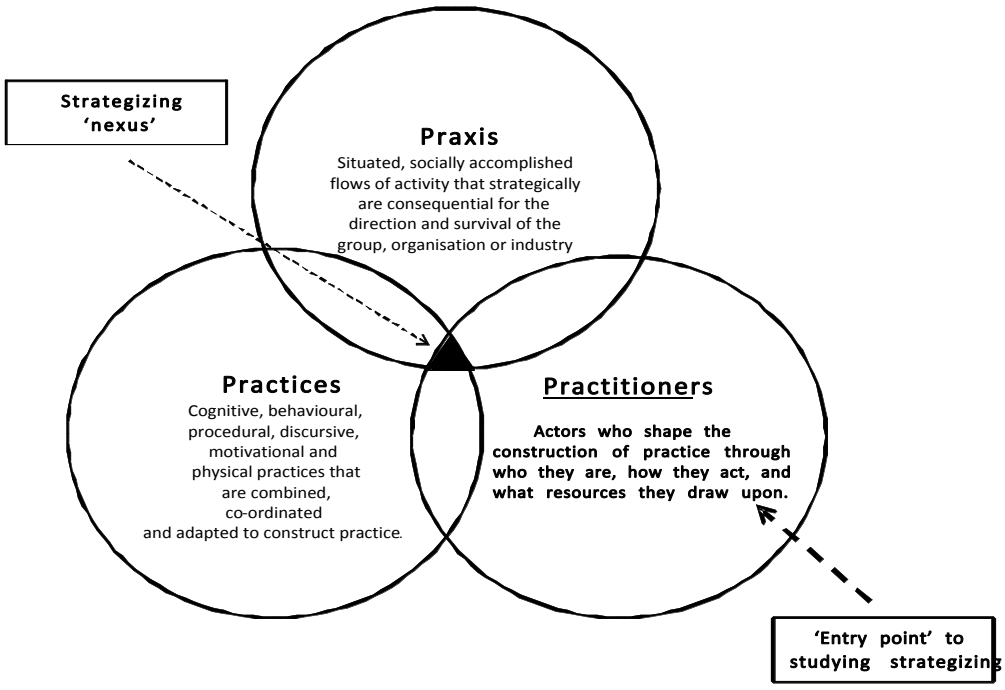
In summary, the role of individuals and groups of actors outside of top management teams, and the context in which they strategize, is a practice concern which this thesis sets out to address.

1.2 The strategy-as-practice conceptual framework

Strategy-as-practice researchers face a number of analytical choices concerning the unit of analysis or dominant analytical focus of study (Jarzabkowski et al, 2007; Johnson et al, 2007). Whittington (2006) has suggested that researchers need to focus on all three elements of strategy which include praxis, practices, and practitioners. Arguably, any attempt at studying in detail all three elements simultaneously risks spreading the scope of study too widely to the extent one's research objectives subsequently become lost.

Although distinct, all three strategy elements are interconnected and overlap at a nexus (see Figure 1.2.1), and as Balogun et al (2007: p201) point out, "it is not possible to study one without also drawing on aspects of the others." However, for research design purposes, practice researchers must have an "entry point" to study strategizing (Jarzabkowski et al, 2007: p8), not only to define their starting point, but also to bound their analytical focus (Langley, 1986, 1989). This case study has two main units of analysis.

Figure 1.2.1 Strategy-as-practice conceptual framework



The primary analytical focus of this study is middle managers therefore, the 'entry point' for this study privileges practitioners over practices and praxis (see Figure 1.2.1), even though it is acknowledged that each of these elements are interrelated. Strategy researchers have traditionally concentrated their efforts on understanding how top managers negotiate change with organizational members (Denis et al, 2001; Eisenhardt & Brown, 1998; Quinn, 1980;

Tushman & Romanelli, 1985). However, from a strategy-as-practice perspective middle managers play a key role also (Balogun & Johnson, 2004, 2005; Laine & Vaara, 2007; Mantere, 2007; Pappas & Wooldridge, 2007; Rouleau, 2005).

The strategy literature often portrays an enduring tension between middle and top management during strategic change which can produce negative organizational outcomes (Balogun & Johnson, 2005; Connors & Romberg, 1991; Currie & Proctor, 2005; Meyer, 2006; Turnbull, 2001), and the nature of the middle manager role during strategic change is frequently debated in terms of whether it is *constructive* or *destructive*. Some researchers (e.g. Balogun, 2003; Fenton O' Creevy, 2001; Giangreco & Peccei, 2005) have noted that there is a tendency within the literature to present a negative view of middle managers, where failure to successfully implement strategic change has been directly attributed to them (Guth & MacMillan, 1986; Meyer, 2006; Thomas & Dunkerley, 1999).

For example, middle managers have been described as the "roadblocks to change" (Graetz, 2000: p556) by impeding the passage of the change process to those within their span of control. Even when middle managers are found to embrace change, credit for successful transformation has been attributed to top management intervention and not to middle managers themselves (Graetz, 2000).

Guth & MacMillan (1986) argued that top management were dependent on middle managers for their technical knowledge and functional skills, yet concluded, "middle management self-interest motivates the degree of commitment to strategy implementation, so divergence between middle management self-interest and organizational interest, as perceived by the general management, is likely to result in ineffective strategy implementation, unless it is anticipated and managed carefully by general [top] management"(p324). Guth & MacMillan added that middle managers who believe their self-interest is being compromised can redirect a strategy, delay its implementation, reduce the quality of its implementation, or sabotage it altogether.

Meyer (2006) presents middle managers as being "destructive" and intentionally derailing the strategy implementation process because "they act according to their self-interests" (p399). Meyer (2006) appears to suggest that middle managers cannot be trusted unless they are closely monitored and controlled by top management. Middle managers degree of omnipotence, and effectiveness, has also been called into question. Nutt (1998) found that top or senior managers are generally more successful than middle managers when participation

and intervention tactics are used by both groups to implement change. He attributed this to middle managers being unable to delegate with the speed that top managers could. Subsequently, their influence had less impact on the change process than that of top managers.

While these researchers question the sincerity and effectiveness of middle managers' actions during strategic change, strategy-as-practice researchers in particular, present a less disparaging view of middle managers by arguing they are "strategic assets" (Balogun, 2003; p69; Floyd & Wooldridge, 1997), and instead choose to illustrate the complexity of the middle manager role within organizations which are undergoing strategic change (Balogun & Johnson, 2005; Hoon, 2007; Laine & Vaara, 2007; Mantere, 2007; Rouleau, 2005).

Spreitzer & Quinn (1996) contend that "middle managers are fighting for their survival in contemporary organizations" (p237) in response to traditional supervisory responsibilities being replaced by self-managing teams and participatory approaches to management. As a result of organizational restructuring in the form of de-layering, middle managers required to redefine their roles which involved "re-orientating" (p237) towards more transformational styles and away from their transactional roles (Bass, 1985). However, the transition process is not a simple one, and can be overwhelming for middle managers. Sims (2003) detailed middle managers narrative accounts of the nature of their role, which describe "special pressures" (p1196) coming from both their subordinates and their superiors. He concluded that what characterizes middle management is a "peculiar loneliness, precariousness, and vulnerability…which may be debilitating for middle management practice" (p1195).

Floyd & Wooldridge (1997) argue that middle managers can, and do, actively participate in the 'thinking' as well as the 'doing' of strategy, while Currie & Proctor (2005) explained how organizational performance in the NHS was heavily influenced by what happens in the middle of the organization rather than the top. Dutton et al (1997) argued that middle managers are often closer to external stakeholders and customers than top managers are, and Rouleau (2005) illustrated this by showing how middle managers' role as 'interpreter' and 'seller' of strategic change contributed to sustaining competitive advantage. Huy (2002) described how middle managers were responsible for ensuring continuity and change took place simultaneously by attending to the emotional needs of change recipients, so that employees continued to be productive during radical change.

Balogun (2003) presents middle managers as "change intermediaries" (p75), as they are required to adopt four inter-related roles during change implementation consisting of undertaking personal change, helping others through change, implementing necessary changes in their departments, and keeping the business going. Balogun (2003) highlighted that a key aspect of this change intermediary position is the interpretation of the change intent, which then informs middle managers actions and impacts on the implementation outcomes, and argued that this provided some explanation for perceived resistance among middle managers and had implications for the way those leading change view the middle management challenge.

These studies all point to the crucial role that middle managers play in strategic change, and that they would appear to hold considerable influence during implementation (Laine & Vaara, 2007; Pappas & Wooldridge, 2007). Indeed, middle managers are often considered by top management to be those directly responsible for the actual implementation of change in the organization (Balogun, 2003; Mantere, 2007), whilst also acting as the 'lynchpin' by connecting strategic and operational levels of the organization during change (Currie, 1999; Floyd & Lane, 2000; Floyd & Wooldridge, 1997; Huy, 2001). Yet, the expectations placed on this role have been found to increase during periods of strategic change (Currie & Proctor, 2005).

For example, Pelligrinelli & Bowman (1994) found that middle managers were formally tasked to be at the centre of strategy implementation in a project management role in addition to their routine activities. The increase in tasks which middle managers must carry out during the change process while 'keeping the business going' (Balogun, 2003), suggests that their capacity to be fully involved in all aspects of implementation could be potentially overwhelming, despite the expectations of their role from top management having simultaneously become greater.

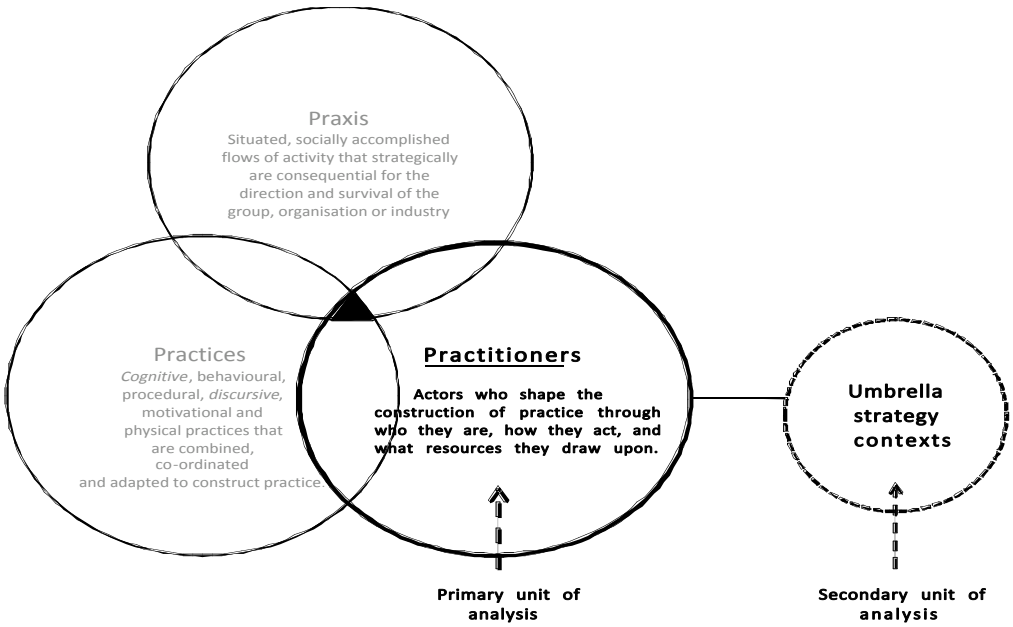
Furthermore, middle managers are often placed in a unique but potentially difficult position, because they require being both active supporters and managers of change whilst also being on the receiving end (Fenton-O'Creevy, 2001). This raises questions about how increased managerial responsibilities and top management expectations affects their level of commitment towards change (Floyd & Wooldridge, 1992), as they attempt to fulfil the broad and wide-ranging intermediary role (Balogun, 2003). It is argued that there is scope for

further examination of the middle manager role, and what they do as strategy practitioners in real-time when faced with such pressures.

Of particular interest to this thesis are middle managers 'mental activities' or 'thinking practices' (Balogun et al, 2007; Melin, 2007), and how they interpret and make sense of the challenges they face during strategic change (Mantere & Vaara, 2008; Rouleau, 2005; Weick, 1995). Melin (2007) has argued that the practice of thinking is an inherent part of strategizing because "strategy as a mental construct bridges the micro process of individual thinking activities and the organizational process of intended, or emergent, strategy outcomes" (Melin, 2007: p217). Action that is grounded in the reason of actors, as well as practical activity and practices, is a key dimension of practice research (Reckwitz, 2002; Regner, 2003; Whittington, 2006).

A secondary unit of analysis is the *strategic context* in which middle managers are situated, and how they evaluate strategic change under umbrella conditions (Mintzberg & Waters, 1985) (see Figure 1.2.2).

Figure 1.2.2 A practitioner focus within umbrella strategy contexts



Even though the general direction of the strategy has been pre-determined and broadly defined by top management through formal planning, top management have only partial control as middle managers are awarded some degree of autonomy and discretion within the

strategy process. The increase in middle managers level of autonomy and discretion, which their strategist role in umbrella contexts affords them, subsequently also allows them to have greater influence on developing the finer strategy details en route (Mintzberg & Waters, 1985).

Connors & Romberg (1991) studied the reactions of middle managers in a large firm when flatter organizational structures were being introduced. They found that middle managers behaved "obstructively" (p61) in an attempt to maintain their power and authority that traditionally separated them from line workers. This included several managers manipulating the implementation of a TQM program to their own best interests, particularly in cases where the strategic directives were ambiguous and left significant room for interpretation.

Similarly, Meyer (2006) describes two middle manager groups who operationalized the strategic plans of four merging Nordic financial institutions in divergent ways, observing "unconstructive middle management intervention was possible because the strategic intent was unclear, had inherent contradictions, and because the top management was largely absent in the implementation process" (p409x). Laine & Vaara (2007) showed how middle managers can initiate and create room for manoeuvre in situations where their development activities are not supported by top management.

A significant gap in the field of strategy research is that we do not know enough about what middle managers *do* with the autonomy and level of discretion awarded to them in umbrella contexts during strategic change (Wooldridge & Floyd, 1990). Although they are allowed room to manoeuvre within the boundaries set out by top management, Mintzberg & Waters (1985) note that these boundaries can often be ambiguous and unclear. For example, how do middle managers make sense of what [deliberately-planned] strategy goals they can modify or what goals they cannot if this is not made explicit by top management? Or where exactly are they permitted to actively participate in the strategy development process and where are they *not* permitted to actively participate?

1.3 Chapter summary

Although there are a number of potential areas to explore in relation to praxis, practices, and practitioners (Jarzabkowski & Spree, 2009), this thesis sets out to examine middle managers interpretative behaviours (Balogun & Johnson, 2004; Reckwitz, 2002), and the rationalizations and justifications (Vaara & Tienari, 2002) that they provide for their actions when developing and implementing an umbrella strategy (Mintzberg & Waters, 1985) (see Table 1.4). More specifically, this thesis is interested in how middle managers confer legitimacy, and commit to, strategic change when an umbrella approach is adopted by organizations, for reasons that are explained in the following two chapters.

Table 1.3 Summarizing the key concepts within a practice perspective

Dominant practitioner focus	Middle managers
Main practices examined	Mental activities or 'thinking practices'
	Discursive practices
	Behavioural practices
	How actors confer legitimacy, and commit to, strategic change
Level of practice	Firm level: where interpretations and narrative may explain the outcomes of strategic change in umbrella strategy contexts
Dominant analytical focus	Practitioners, followed by practices, then praxis
Theoretical bases	Sensemaking theory
	Narrative theory

CHAPTER 2

THE PROBLEMS ASSOCIATED WITH STRATEGIC CHANGE

Introduction

The purpose of this chapter is to draw on the strategic change literature that highlights what managers *do*, and the *context* in which they do things. It summarises those problems that are commonly associated with implementing strategic change such as different managerial practices and contextual factors, all of which have been offered as explanations for variation in change outcomes. It highlights the emphasis that strategy researchers place on the challenge of gaining legitimacy for strategic change, and the importance of attaining actor's commitment when managing implementation. It questions the normative view in the strategy literature which suggests that there is a reciprocal relationship between legitimacy and commitment during the strategy process which consequently supports successful strategic change.

The chapter concludes by identifying a major research gap in relation to the lack of conceptual clarity around the constructs of legitimacy and commitment within strategy discourse (Golsorkhi et al, forthcoming; Johnson et al, 2007; Meyer & Allen, 1997; Suchman, 1995), which has significant implications for the normative views' claim of reciprocity.

2.1 General themes in strategic change research

Strategic change is often reported as failing to achieve its original objectives and failure rates are reported to be as high as 70% (Beer & Nohria, 2000). Many researchers have highlighted that a key factor in strategy failure is attributable to issues around poor implementation (Nutt, 1999; Noble, 1999; Whittington, 2001). Some have argued that the execution of strategic goals is more difficult in practice in comparison to the design and development process which involves less time, less cost, and less preparation (Hbreniak, 2006; Miller et al, 2004).

Despite some recognition that implementation processes "matter" (Godard, 1999: p679) and that decisions which fail to be implemented can be costly (Nutt, 1998), researchers continue to note that comparatively less attention has been given to implementation issues within the strategy literature when compared to the volume of research relating to planning (Chebat, 1999; Dromgoole et al, 2000; Hickson et al, 2003; Hrebiniak & Joyce, 2001; Mintzberg et al,

2009; Noble, 1999; Vicente-Lorente & Zuniga-Vicente, 2006). However, the importance of implementation research continues to be supported on the basis that successful management of implementation has major implications for determining economic performance (Covin et al, 1994), evaluating the deployment of resources (Nutt, 1998), and because a firm's capacity to manage strategic change successfully can be a critical source of competitive advantage (Pettigrew & Whipp, 1991).

Strategy implementation typically involves more people than planning (Hrebiniak, 2006). Organizations are often faced with a number of issues such as managing communication horizontally and vertically across different functions of the organization (Beer & Eisenstat, 2000; Hambrick & Cannella, 1989; Hrebiniak, 2006; Rapert et al, 2002), determining who has ownership and control of the process (Eden, 1993; Mintzberg & Waters, 2002), satisfying competing stakeholder interests and tensions (Freeman, 1984; Johnson et al, 2008; Nutt et al, 2000; Mason & Mitroff, 1981; Miller et al, 2004), and addressing competing organizational demands where multiple goals are often being implemented at any one time but where multiple strategies or strategic goals conflict, compete, or are so complex they are difficult to manage and control (Beer & Eisenstat, 2000; Govindarajan, 1988; Jarzabkowski & Sillince, 2007; Miller et al, 2004).

Although it is generally acknowledged that there is 'no one best way' to manage strategic change (Burnes, 2004; Dunphy & Stace, 1990; Pettigrew et al, 1992) the implementation literature has long held a tendency to oscillate between citing a wide variety of 'critical success factors' whilst simultaneously diagnosing 'reasons for failure' (e.g. Beer et al, 1990; Beer & Eisenstat, 2000; Bryson & Bromiley, 1993; Hambrick & Cannella, 1989; Hickson et al, 2003; Hrebiniak, 2006; Kotter, 1995, 2000; Nutt, 1999; Pellegrinelli & Bowman, 1994; Pinto & Prescott, 1990; Rapert et al, 2002; Reed & Buckley, 1988; Reger et al, 1994).

Consequently, the dominant approach within the research community which has chosen to examine this area has tended to focus on producing prescriptive implementation models (Andrews, 1987; Bourgeois & Brodwin, 1984; Flood et al. 2000; Govindarajan, 1988; Guth & MacMillan, 1986; Hardy, 1994; Hrebiniak, 2006; Kaplan & Norton, 1992, 1996, 2004; Lord, 1993; McCalman & Paton, 2008; Nutt, 1989; Nutt et al, 2000; Pellegrinelli & Bowman, 1994; Reed & Buckley, 1988; Thompson et al, 2006), and the benefits of such models are lauded because they promise to ensure that "implementation is unambiguous" (Pellegrinelli & Bowman, 1994: p128) by "combining the use of goal-setting and critical success factors…

with performance appraisal and feedback mechanisms that can facilitate the strategy implementation process" (Reed & Buckley, 1988: p67).

Although these models serve as practical strategy tools and remain attractive to practitioners due to their "strategic change logic" (Nutt et al, 2000: p29), they have also received much criticism. For example, Raimond & Eden (1990) have argued that the critical weakness of implementation models is their lack of appreciation of the competing pressures that can subvert certain key objectives, while Sull (2004) highlights their failure to take into account forecasts and analyses changing from the planning period as events begin to overtake original implementation objectives. Therefore, models may fail to recognize that strategy goals require to be altered because initial conditions become subject to "slippage" (Pressman & Wildavsky, 1984; p23). This problem can be compounded due to model rigidity and inflexibility (Pelligrinelli & Bowman, 1994).

There remain fewer studies which have considered how strategic decisions are implemented in practice and the factors that influence their success (e.g. Butler, 2003; Godard, 1999; Hickson et al, 1986; Miller, 1997; Miller et al, 2004; Nutt, 1998; Reger et al, 1994; Skivington & Daft, 1991) in contrast to the majority of implementation studies whose output tends to result in the design of additional prescriptive models. It is argued that the explanatory value of prescriptive implementation models is limited as they fail to account for the practices that shape change outcomes. Even so, many implementation researchers continue to call for more prescriptive models to be developed which can effectively guide the process of strategic change (e.g. Hrebiniak & Joyce, 2002; Nutt, 1998; Noble, 1999).

The strategy-as-practice perspective addresses this issue by proposing that researchers require to look beyond such rationalistic models and instead give more attention to what it is that actors are actually *doing* during strategic change (Johnson et al, 2003), and by taking cognisance of the *strategic context* in which actors are situated (Rouleau et al, 2007; Whittington, 2004). It is argued that a deeper understanding of the factors which influence the strategic change process can be better achieved by analyzing the micro-level practices and strategizing activities of key actors which can be consequential for strategic outcomes (Jarzabkowski et al, 2007), as opposed to the development of another prescriptive model for implementation.

2.2 Managerial practices which impact on change outcomes

What managers *do* during strategic change has been found to play a significant role in affecting change outcomes. In practice, top managers are thought to spend more time and energy on implementing strategies than choosing them (Whittington, 2001), yet some researchers question whether top management genuinely consider implementation as a priority and accuse them of under-emphasizing the importance of strategy execution within their organizations (Eisenhardt & Brown, 1998) and treating implementation as "a strategic afterthought" (Noble, 1999: p119).

Darragh & Campbell (2001) found that almost a third of corporate initiatives fail because they "got stuck" (p33) as a consequence of not having been given the level of managerial priority they required. Studies have found that low prioritization can cause longer-term difficulties because top management avoid resolving strategy-orientated issues upfront prior to implementation commencing, and this factor has been found to markedly decrease the likelihood of strategy success (Pinto & Prescott, 1990; Reed & Buckley, 1988). The consequences of failing to address change-related issues beforehand is that core tensions which are unresolved and are left unmanaged tend to resurface when implementation begins and create further problems (Nutt et al, 2000).

Some researchers have suggested that this problem is due to managers appearing to know more about developing and formulating strategy than they do about executing it due to the orientation of MBA programmes where execution is not emphasized enough (Hrebniak, 2006; Mintzberg, 2004). Chebat (1999) argues that this problem lies in the managerial view of implementation which is perceived as "mechanistic and unromantic" (p108) in comparison to the creativity required for formulation.

Even when implementation *is* given priority by top management, poor coordination across business functions has been cited by as 'a barrier to implementation' (Beer & Eisenstat, 2000). Hrebiniak (2006) has argued that effective coordination cannot occur if managers do not know who is responsible for what when they are managing activities which may be interdependent of other business units. Some claim this factor is the main reason strategic initiatives are never realized and because project management tools and techniques for coordinating multiple strategic goals have not been applied (Kaplan & Norton, 2004; Pellegrinelli & Bowman, 1994; Pinto & Slevin, 1987). Without a framework to plan and

monitor progress, little control is exercised to ensure that goals are being achieved and managers' subsequent understanding of the implementation process is poor (Lord, 1993).

Managerial interest in implementation has been noted to fluctuate, and some studies show that many appear unwilling to follow-up on implementation (Heide et al, 2002; Pinto & Prescott, 1990). Beech (2000) highlighted that some managers did not think it was their role to actually implement changes, while Nutt (1989) found managers prone to taking "implementation short cuts" (p145) that minimized their involvement. Hrebiniak (2006) attributes managerial loss of interest to implementation being played out over a much longer period of time than formulation.

Miller et al's (2004) study demonstrated that different organizations have different cycles for implementation, ranging from three to sixteen years, and this can make it harder for managers to focus on, control, and retain interest in the execution process, particularly when some managers can be impatient for success to materialize. This may be exacerbated by unforeseen and unexpected events materializing which challenge managers' attention (Balogun & Johnson, 1998; Hrebiniak, 2006). Instead, managers 'muddle through' (Lindblom, 1959) and initial momentum is lost before the expected strategic benefits are realized (Pelligrinelli & Bowman, 1994).

Miller et al (2004) found that managers can plan the implementation of a decision better when they know how to do so from previous experience, while those who advocate contingency approaches have called for a 'repertoire of tactics' to be used according to different 'implementation conditions' (Lorange, 1978; Nutt, 1989). However, where previous experience is lacking and repertoire is limited, some managers have been found to devise a preferred way to deal with implementation and use it exclusively (Nutt, 1987), even though "the routine application of tactics that are effective in one situation can create 'overkill' in another, and fail in still another" (Nutt, 1989: p148).

Nutt (1989) found that managers appear to apply implementation tactics indiscriminately. However, Miller & Chen (1996) argued that the reason managers adopted single-faceted and one-dimensional approaches to implementation was because they connected better to notions of 'simplicity' as opposed to confronting the complexity of managing strategic change. Hafsi (2001) found that managers tended to stick to oversimplified ideas or tools to purse implementation because they were overwhelmed by the complexity of change in their

organization. He observed that managers were drawn towards the less critical and more routinized processes of managing change and away from emerging critical issues.

Argyris (1989) contends that organizations fail to engage in learning during the implementation process, and instead develop 'organizational defensive routines.' Managers commit to any policy, practice, or action that prevents people involved from being upset, embarrassed, or threatened, by individuals 'going along' with decisions which are contrary to one's personal beliefs, but which one is emotionally committed to for the sake of someone else. Top management groups subsequently avoid challenging each other's positions or explicitly voicing their concerns.

Routines also consist of managers *acting* as though problems do not exist by withdrawing from conversations where conflicting views surface, and by withholding objections to strategic decisions during formulation, until they reach the implementation stage. Consequently, the strategy implementation process is impeded as routines are considered to limit learning, discourage candid enquiry, and can lead to perceptual gaps and differences in understanding strategic issues between organizational members (Argyris, 1989).

Two observations from the strategic change literature are important to this thesis. First, much of the literature emphasizes the practices and doings of top managers (Darragh & Campbell, 2001; Eisenhardt & Brown, 1998; Hambrick et al, 1993; Lyles & Schwenk, 1992; Quinn, 1980), as opposed to those outside of top management teams (Balogun et al, 2007).

In particular, the literature on 'change leadership' tends to focus upon the omnipotence of leaders during strategic change, the personal qualities they ought to possess, what types of roles they should adopt in order to lead change effectively, and how they must behave differently in different strategic change situations (Andrews, 1980; Bass, 1985, 1990; De Wit & Meyer, 1998; Gill, 2001, 2002, 2003; Kets de Vries, 2001; Kotter, 1990, 1995, 1996; Miller et al, 1982; Nadler & Tushman, 1990; Quinn, 1996; Schein, 1992; Stace & Dunphy, 1996; Stogdill, 1974; Yukl, 2002). For example, Tushman & Romanelli (1985) claim that "only executive leadership is able to initiate and implement strategic reorientations" (p214). Similarly, Andrews (1981) argues that "ultimately there is only one strategist, and that is the manager who sits at the apex of the organizational hierarchy" (cf. Mintzberg et al, 2009: p31), while Porter (2005) emphasizes "the striking relationship between really good strategies and really strong leaders" who are "the chief strategists" (p44).

However, the notion that charismatic individuals at top executive-level single-handedly change organizations has been challenged, as many other organizational actors also contribute to the change process (Ackermann & Eden, 2005; Mintzberg, 2007), such as middle managers (Floyd & Wooldridge, 1997; Laine & Vaara, 2007). Most organizations are too large and complex for any one executive to manage directly (Pettigrew, 1987). Denis et al (2001) have demonstrated that change leadership is not always just about one individual, but can also be a collective phenomenon in which many group members play complementary roles and where different individuals can contribute in different ways, while Pettigrew & Whipp (1991) showed that strategic change in the large firms they studied often involved many individuals.

The role of top management is only one of many important ingredients in creating successful strategic change, as transformation involves many political and cultural issues within the organization which influence change outcomes despite high-level intervention (Pettigrew, 1987). Furthermore, the notion of top management change leaders acting as 'visionaries' has its limitations when applied in umbrella contexts (Mintzberg & Waters, 1985). It remains unclear how top managers can communicate a vision when a strategy has not actually been fully articulated at the top of the organization, either by one individual or collectively, hence the need to co-opt those outside of top management teams into the strategy development process (Laine & Varra, 2007; Suchman, 1995).

It is argued in this thesis that the practices of middle managers are also critical to the development of strategic change (Westley, 1990), particularly as they are formally awarded the role of 'strategist' in umbrella strategies (Jarzabkowski et al, 2007). As other practice researchers have noted, the role of middle managers in the strategy process is of theoretical and practical importance to better understand the strategic change process (Balogun & Johnson, 2005; Floyd & Wooldridge, 2000; Mantere & Vaara, 2008).

Second, although the cognitive processes, sensemaking, or 'thinking practices' underlying actors' responses to organizational change have been given attention by strategy researchers (Balogun & Johnson, 2004, 2005; Barr, 1998; Bartunek, 1984; Gioia et al, 1994; Isabella, 1990; Labianca et al, 2000; Lau & Woodman, 1995; Maitles, 2005; Poole et al, 1989; Rouleau, 2005; Walsh, 1995), there remains a strong emphasis within the strategic change literature on the behavioural aspects of managerial practice in terms of actions and observable activities (Coch & French, 1948; Kotter, 1995; Lewin, 1949).

Concerns about the behavioural emphasis on strategists' practices and activities have been expressed by Melin (2007), who has highlighted the potential for strategy-as-practice researchers in following those traditional approaches that focus too heavily on action.The detailed aspects of managerial thinking activities and reasoning, and their contextual embeddedness, remain less well understood during strategy execution (Regner, 2003).

Although studies which highlight the behavioural practices of middle managers remain important to developing a better understanding of their strategic activities, greater analytic focus on managers' thinking practices may provide some insight into the process of strategic change that a sole emphasis on behavioural practices cannot.

2.3 Contextual factors in strategic change: planning versus participation

A number of different approaches are available to organizations when embarking on strategic change (Johnson et al, 2008; Mintzberg et al, 2009; Whittington, 2001). Mintzberg & Waters (1985) have identified a range of strategies and their features to illustrate the distinctions between eight particular approaches (see Table 2.3).

Table 2.3 Summary description of types of strategies (Mintzberg & Waters, 1985)

Strategy	*Major features*
Planned	Strategies originate in formal plans: precise intentions exist, formulated and articulated by central leadership, backed up by formal controls to ensure surprise-free implementation in benign, controllable or predictable environment; strategies most deliberate.
Entrepreneurial	Strategies originate in central vision: intentions exist as personal, unarticulated vision of a single leader, and so adaptable to new opportunities; organization under personal control of leader and located in protected niche in environment; strategies relatively deliberate but can emerge.
Ideological	Strategies originate in shared beliefs; intentions exist as collective vision of all actors, in inspirational form and relatively immutable, controlled normatively through indoctrination and /or socialization; organizations often proactive vis-à-vis environment; strategies rather deliberate.
Umbrella	***Strategies originate in constraints; leadership in partial control of organizational actions, defines strategic boundaries or targets within which other actors respond to own forces or to complex, perhaps unpredictable environment; strategies partly deliberate, partly emergent and deliberately emergent.***
Process	Strategies originate in process: leadership controls process aspects of strategy (hiring structure, etc.), leaving content aspects to other actors; strategies partly deliberate, partly emergent (and, again, deliberately emergent).

Unconnected	Strategies originate in enclaves: actor(s) loosely coupled to rest of organization produce(s) patterns in own action in absence of, or in direct contradiction to, central or common intentions; strategies organizationally emergent whether or not deliberate for actor(s).
Consensus	Strategies originate in consensus: through mutual adjustment, actors converge on patterns that become pervasive in absence of central or common intentions: strategies rather emergent.
Imposed	Strategies originate in environment: environment dictates patterns in actions either through direct imposition or through implicitly pre-empting or bounding organizational choice; strategies most emergent, although may be internalized by organization and made deliberate.

Based on the eight approaches identified in Table 2.3, this thesis is specifically interested in *umbrella strategies*, which combine deliberate *and* emergent processes (Mintzberg & Waters, 1985). This type of strategy is particularly interesting for three reasons.

First, as this approach involves deliberate planning *and* emergent participation, attention is now given to the planning and participation-related literatures from the strategy and HRM fields, as these offer views on the benefits and drawbacks of using both planning and participation approaches as part of the strategy process.

The normative approach to strategic management typically involves planning (Grant, 2003; Mintzberg, 1994). The planning school in the strategy field places much emphasis on approaches which are deliberate (Ansoff, 1965; Chandler, 1962; Lorange, 1980). The school's characteristics, which include economic-orientated analytical processes that constitute most MBA programmes (Mintzberg, 2004), and its assumptions about the predictability and stability of environments (Schwartz, 1991), have been cited as playing a significant role in shaping the belief among managers that planning is the most important element of the strategic change process (Mintzberg, 1994).

Hrebiniak (2006) summarizes the planning school perspective by stating, "Without guidance, individuals do the things they think are important, often resulting in uncoordinated, divergent, conflicting decisions and actions. Without the benefit of a logical approach, execution suffers or fails because managers don't know what steps to take and when to take them. Having a model or roadmap positively affects execution success; not having one leads to execution failure and frustration" (p17). Hrebiniak (2006) found that when a strategy is perceived by change recipients to be vague, implementation efforts are likely to be limited as actors do not understand what is required from them, because responsibilities and lines of accountability remain unclear, and goals are inadequately specified at the outset.

However, the planning school has drawn much criticism for its unyielding position on formal plans and controls to ensure "surprise-free implementation" (Mintzberg, 1994: p221), and for treating the participation of those out-with top management as "a non-issue" (Mantere & Vaara, 2008: p342). Quinn (1980) highlighted that the formal planning approach underemphasized the "vital power-behavioural factors that so often determine strategic success" (p15), and that planning activity itself was considered by many executives to be "a bureaucratized, rigid, and costly paper-shuffling exercise" (p2).

The view of processualists is that the planning tradition over-emphasizes and exaggerates the merits of planning and analysis (Whittington, 2001). For example, Mintzberg (1994) has argued that managers have developed over-optimistic expectations about what strategic planning will achieve. The "fallacy of planning" is that careful managerial planning does not of itself guarantee successful strategic management outcomes (Mintzberg, 1994: p159). While Miller et al (2004) have argued, that planning is not indispensable to a successful implementation, because the importance of planning lies as much in its latent function of creating organizational confidence, and a favourable disposition towards implementation, as it is in its function of detailing implementation activities.

Ackermann & Eden (2005) maintain that strategic planning efforts come to nothing because they do not directly involve the power brokers but rely on support staff, and that those who are involved take an idealized view of the organization and what it can achieve. Strategic planning is merely an "annual rain dance" of no practical support (Ackermann & Eden, 2005: p2). The value of planning to firms operating in turbulent environments has also been questioned (Langley, 1988).

The planning school have also been accused of being responsible for reinforcing the view among managers that formulation and implementation are distinct processes (Mintzberg, 1990, 1994, 2007), and that implementation is a top-down process which requires change to be pushed down through the organization following planning (Balogun et al, 2007; Beer et al, 1990). From a planning perspective, top managers tend to view strategy implementation as the work of other lower-level employees further down the organization, and believe their own role is to plan while the role of others is to carry out top level demands and implementation requirements (Hrebiniak, 2006). The failure of managers to adopt an integrated view of strategy, and acknowledge that implementation can be managed from the middle of the

organization, has been cited as reasons for implementation failure (Chebat, 1999; Floyd & Wooldridge, 1990; Hrebiniak, 2006).

Hamrick & Cannella (1989) have pointed out that a great strategy is only 'great' if it can be implemented, and Pressman & Wildavsky (1984) note that a strategy's value must be measured not only in terms of its appeal, but also in light of its implementability. Managers have been found to "become upset when expected events turn out badly" (Pressman & Wildavsky, 1984: p15), and some researchers argue that this is due to management complacency which often follows the planning stage because managers become over-confident about their carefully formulated strategies by believing that implementation will seamlessly follow (Mintzberg, 1994; Noble, 1999).

The sense of achievement which accompanies a successful planning process also appears to create over-inflated management expectations of implementation (Pressman & Wildavsky, 1984). As Beer & Eisenstat (2000) have observed, "senior managers get lulled into believing that a well-conceived strategy communicated to the organization equals implementation" (p29). The consequences of managers adopting such a strong pro-planning bias is that when problems arise during implementation they discover that it is often too late, or they become reluctant, to go back and modify their plan (Hambrick & Cannella, 1989).

The planning school creates the expectation that planning can act as a control mechanism against managerial agency, and that by pre-empting problems prior to implementation can prevent "individuals pursuing activities which will be detrimental to the organization" (Reed & Buckley, 1988: p70; Nutt et al, 2000). Beer et al (1990) suggest that some managers follow the dictum that employee behaviour can be changed by altering a company's formal structure and systems. However, as strategy is also an emergent process (Balogun, 2006; Eden & Ackermann, 1998; Mintzberg et al, 2009), the view that all problems can be "pre-empted" (Reed & Buckley, p70) has been challenged. It cannot be known *a priori* through forecasting what the exact nature of implementation problems will be (Mintzberg, 1994), and impossible for top management to predict all the events and forces that will come to shape the future of the firm (Quinn, 1980).

At the other end of the spectrum, less formal approaches that involve less planning but more emphasis on emergent participative processes to support strategic change, includes greater employee involvement and participation in strategy development (Lines, 2007; Mantere & Vaara, 2008; Sagie & Koslowsky, 2000). Some researchers claim that organizations face

institutional pressures to adopt participative approaches to strategic change, and only do so in order to gain organizational legitimacy (Lines, 2007; DiMaggio & Powell, 1991). However, the general view from the HRM literature is that organizations should attempt to make change processes as inclusive as possible in order to create a sense of employee ownership and increase commitment to change (Beer et al, 1984; Guest, 1989; Marchington, 1987).

Empirical studies have shown that employee involvement in the strategy process has implications for organizational commitment, job satisfaction, and work-related attitudes (Oswald et al, 1994; Rapert et al, 2002; Swanberg-O'Connor, 1995). The probability of implementation success has been found to be higher if managers have participated in the strategy decision-making process as they tend to stay involved in implementation (Kim & Mauborgne, 1998; Korsgaard et al, 1995; Miller et al, 2004), but also where there is greater interaction between 'doers' and 'planners' during planning and formulation (Hrebiniak, 2006).

Shapiro (2003) has argued that a disproportionate level of attention is given to the project management aspect of change implementation (i.e. models, documented processes) over issues of participation and how people will adapt to change. Consequently, implementation is more likely to fail because top management award less attention to creating an environment which supports those expected to make the change and to influence their attitudes towards it.

The issue of who should be involved or considered by top management as a strategist, can be an inherently political one (Johnson et al 2008; Lynch, 2003). Participation, and recruiting certain people into the strategy-making process, can also be a useful mechanism for "winning people over" (Ackermann & Eden, 2005: p27). When formulating goals, top management seek to benefit from others knowledge via their participation, but in doing so, also obtain the commitment of those who possess this knowledge (Quinn, 1980).

The working assumption that underlies allowing wider participation and co-opting other members outside of top management into the strategy process, is that it enhances the chances of the resulting strategies being implemented successfully (Ackermann & Eden, 2005). Stakeholders react more favourably and become more committed if they participate in the change-making process (Coch & French, 1948). Poor engagement with key managers has been noted to create problems for the implementation of strategic plans (Balogun & Johnson, 2004; Floyd & Wooldridge, 2000; Laine & Vaara, 2007; Westley, 1990).

However, there are a number of associated risks with participation that can be consequential for strategic outcomes. For example, the 'classical school,' as described by Whittington (2001), emphasizes to managers that loss of top management control through the initiation of inclusive and participatory approaches can lead to implementation failure (Chandler, 1982; Lorange & Vancil, 1977; Reed & Buckley, 1988). Indeed, Nutt (1999) reported that top managers tended to avoid participation in implementation because of its time requirements and the loss of managerial control that can result from the involvement of more actors. Quinn (1980) found that some executives viewed participation as frustrating, wasteful, or even divisive.

Chakravarthy & Garguilo (1998) point out that participation alone cannot generate the necessary support for strategic change as procedural fairness is also necessary. Participative strategic decision-making redistributes power beyond top management teams which can create rivalry and intra-organizational conflict during implementation (Hardy & Leiba-O'Sullivan, 1998; Knights & Morgan, 1991; Korsgaard et al, 1995; Pfeffer, 2002). The use of 'delegative participation' (Geary, 1994), which allows employees to take on decisions that had traditionally fallen within the top management prerogative, may be well-intentioned (McKenna & Beech, 2002), but it can also encourage managerial agency which produces negative consequences for the strategic change process (Angwin, 2007; Eisenhardt, 1989; Guth & McMillan, 1986; Meyer, 2006).

Where conflicts are not initially surfaced prior to execution e.g. via a consultation process, they often emerge during implementation and adversely affect the strategy process, as organization members fail to operate under the same goals and objectives (Noble, 1999). Autonomous behaviours may emerge and these can have a profound effect on implementation as managers intentionally deviate from strategy goals to pursue their own desired ends (Caldwell, 2006; Guth & McMillan, 1986; Noble, 1999). Acts of managerial agency may be consciously enacted despite managers recognizing the need for change, but they instead adopt a position which is "based on a very shrewd appreciation of the personal consequences [of change]" (Whittington, 2001: p114).

Researchers continue to highlight the capacity of managers' ability to steer the direction of the strategy implementation process in an unintended direction, despite token gestures of compliance (Lines, 2007; Miller et al, 2004; Nutt, 1983). However, in spite of the risks attached to embracing the involvement and participation of those outside of top management

teams in the strategy development process, the normative view within the management literature is that a participative approach is desirable and key to gaining employee commitment (Argyris, 1998; Burnes, 2004; Child, 1976; Iverson, 1995; Kim & Mauborgne, 1998; Korsgaard et al, 1995; McKenna & Beech, 2002; Pugh, 1993; Shapiro, 2003).

Whether a planning or participative approach is more likely to produce successful strategic change is a separate matter of debate (Lines, 2007; Mintzberg et al, 2009; Sagie & Koslowsky, 2000), and one which is not the focus of this thesis. Instead, what is of interest is the outcome of strategic change when both deliberate planning *and* emergent participative approaches are used in chorus, and what it is that middle managers *do* as part of this process.

Second, researchers have highlighted that a common characteristic of deliberately-emergent strategies are the simultaneous use of 'edicts' (i.e. directives that convey what the broad principles must achieve), and 'participation' (i.e. via co-optation) (Quinn, 1980; Mantere & Vaara, 2008; Vila & Canales, 2008).

In several studies, Nutt (1986, 1987, 1989, 1998, 1999) analyzed implementation tactics which managers used to elicit support, cooperation, and acquiescence in order to ensure implementation compliance. He identified four tactics that managers used to implement strategic plans: intervention, persuasion, participation, and edict.

Intervention involved an individual manager being delegated the authority to make changes required by a strategy, and who readies the organization for change by justifying the need to change by identifying a performance gap, while highlighting the experiences of comparable organizations in order to convince others that action is both desirable and feasible. This approach is considered to have its roots in Lewin (1948) and Schein's (1964) notion of change agency. *Persuasion* involved top management 'selling' the change to others by means of gathering documentation to support the merits of their decision.

Participation involved selecting or inviting group members with a vested interest in the strategy, as a way to ensure that key points of view would be represented and that information and ideas could be offered (Nutt, 1989). The participation tactic is used to co-opt members into the decision-making process, and these members must endorse decisions before implementation can proceed. They also review and modify plans, as well as specify terms of implementation as they assess the implications of any changes (Nutt, 1989). *Edicts* typically involved writing a memorandum which explained the new strategy and when it would go into

effect. These were issued without consulting change recipients. Edicts tend to draw on one or more of the manager's power bases which are based on rewards, inducement, coercion, information, expertise, and charisma (French & Raven, 1959).

A consistent finding from Nutt's studies is that 'intervention' was found to be the most successful tactic to implement strategic decisions, when a manager took charge and created an environment where plans could be justified and understood in less time (Nutt, 1987, 1998). Managers who made the need for action clear at the outset, set objectives, carried out an unrestricted search for solutions, and ensured key people participated in strategy decision-making processes, were more apt to be successful (Nutt, 1999). Implementation success was more likely when interventionist and participative approaches were used in tandem, as opposed to persuasion and edicts which were generally more unsuccessful (Nutt, 1998).

Implementation failure was linked to managers who imposed edicts and solutions. Those managers who routinely used edicts developed a reputation for being heavy-handed and putting their decisions in jeopardy (Nutt, 1999). Edicts directed attention away from the merits of the decision and toward the manner in which implementation is attempted. Considerable expense, time, and effort are then expended trying to overcome the resistance provoked by an edict. More often than not, these efforts failed, no matter what the decision's merits (Nutt, 1989, 1999).

The importance of these studies to this thesis is that Nutt's (1986, 1987, 1998) analysis identified a number of 'hybrid cases' that involved the use of more than one tactic[1]. The prevalence of hybrid cases in the 1986 study was 7%. Nutt (1986) commented, "The [combined] tactics used, their order, and their relative emphasis all seem important. However, there were too few hybrid cases to show if the use of combinations meant managers were groping for correct tactics, with the last tactics used being their choice, or if the combinations themselves gave improved leverage. Hybrids may signal managerial errors or the emergence of different implementation needs at different stages of the development" (p251). Nutt (1986) concluded, "Only 7 % of the cases were classified as hybrids, suggesting that this type is rare" (p251). The 1987 study findings found that the prevalence of hybrid cases was 9%. No analysis of hybrid cases was undertaken. Nutt (1987) states, "There were too few hybrid cases to permit analysis so they were deleted from the study" (p4).

[1] No hybrid approaches are noted in Nutt's 1989 and 1999 studies, therefore, no prevalence rates are provided

The 1998 study findings found that the prevalence of hybrid cases was 4% and, in contrast to the other studies, an analysis of hybrid cases was carried out. Nutt (1998) identified the combination of *interventionist-participative* and *persuasion-edict* approaches within this 4% of hybrid cases. However, the incidence of *edict-participation* combinations is not clear, as no reference is made to this type of hybrid approach in Nutt's (1998) analysis. Nutt (1998) commented, "Hybrids seemed to represent a hodgepodge of activity, without any apparent reason behinds the shifts in approach." He concluded, "There were too few cases in these hybrid categories to permit analysis, so they were not considered further" (p223)[2].

Nutt's implementation studies are an important contribution to understanding what top managers *do* in the strategy process. These studies also provide particularly useful lessons for managerial practice. However, Nutt's 1986, 1987, and 1998 findings, that there were few hybrid cases that combined *edict-participation* combinations, are somewhat surprising, as it is this hybrid approach that typifies the tactics deployed by top management in umbrella strategies (Mintzberg & Waters, 1985; Quinn, 1980).

Nutt's findings conflict with Mintzberg & Water's (2002) view that umbrella approaches are most representative of what firms do in reality as "virtually all real-world strategies have umbrella characteristics" (p22) i.e. they use edict-participation hybrid combinations. Johnson et al (2008) also support this view by commenting that the umbrella approach is similar to the descriptions that managers themselves give of how strategies come about in their organizations (p409-410), while Quinn (1980) reported that new sets of strategic goals rarely emerge full blown from individual bottom-up proposals or from comprehensive corporate strategic planning (p87).

These conflicting accounts about 'real-world strategies' and the everyday use of edict-participation hybrid combinations suggests that further research is required to examine what firms actually *do* when strategizing, especially in cases where edict and participation tactics are deployed concurrently. The prevalence rate of hybrid approaches is not the subject of this

[2] I discussed these studies' findings with Professor Nutt in a Q&A session that followed a seminar held at Strathclyde Business School in 2008. I asked him specifically about the data relating to his ongoing research on the use and efficacy of implementation tactics. He confirmed that only top managers, and not middle managers, were used as part of his sample groups. This reason for choosing top managers was a personal research design decision. I also asked him why he chose not to carry out further analysis on hybrid combinations, especially on the simultaneous use of edict-participation tactics. Further exploration of hybrid approaches was not possible in a practical sense because he was dealing with such large sample sizes and high volumes of quantitative data to analyze, and that looking at hybrid combinations and their effects was not the analysis priority or directly related to the aims of these studies and their research questions. It was instead focused more specifically on the four tactics, and their success and failure in implementing strategic decisions.

thesis. However, from a strategy-as-practice perspective, edict-participation hybrid approaches may be consequential for firm outcomes (Jarzabkowski et al, 2007). Their effects on managerial practices are critical to developing a better understanding of umbrella strategies, in addition to the role and 'lived experience' of middle managers when this type of hybrid approach is adopted by firms managing strategic change (Samra-Fredericks, 2003).

Third, a review of the strategy literature shows that there is a very limited, and disproportionately low, volume of research output on umbrella strategies. Vila & Canales (2008) have suggested that a firm's approach to strategic management is an important determinant of successful implementation, yet few researchers have given attention to the practices and outcomes associated with a deliberately-emergent approach, or make specific reference to Mintzberg & Water's (1985) umbrella-type.

For the most part, umbrella strategies appear to have been overlooked by strategy researchers. This can perhaps be attributed to the formulation-implementation dichotomy which has characterized the strategy field, whereby less integrative but more partisan positions have been adopted by strategy researchers (Jarzabkowski, 2005). From the small number of studies that have implicitly or explicitly referred to umbrella approaches, some interesting insights into the use and effectiveness of deliberately-emergent strategizing have been offered. However, these studies also provide scope for further research on umbrella strategies on a number of levels.

For example, Quinn's (1980) concept of 'logical incrementalism' reflects closely the features of Mintzberg & Water's (1985) umbrella strategies. It encapsulates processes that bridge intention and emergence, in that they are deliberate and intended but they also rely on social processes within the organization to sense the environment and experiments in subsystems to try out ideas (cf. Johnson et al, 2008: p409). In a study of nine major multinational businesses, Quinn (1980) set out to identify some common patterns of strategic action to better understand how [top] managers in complex situations acted, and to compare their actions and viewpoints to current theories of strategic management.

Quinn (1980) found that what characterized executives strategizing activities was not guided or dependent upon rigorous analytical procedures as promoted by the planning school, but instead *the combination* of formal analytical, behavioural, and political processes. Managers did not follow highly formalized textbook approaches in setting and analyzing their goals, but they were sensitive to organizational and power relationships in building consensus and

creating commitment to strategy goals. The most effective top executives typically announced "only a few broad goals from the top, and encourage their organizations to propose some also, and allow others to emerge from informal processes" (p91). Quinn (1980) also found that strategic decisions did not come solely from power-political interplays, nor did they lend themselves to aggregation in a complex decision matrix where all factors can be treated quantitatively. Instead, both of these factors were synthesized into "an integrated methodology" (p98).

A number of characteristics of logical incrementalism mirror those of umbrella strategies. For example, top managers systematically co-opted others into the strategy process in order to build organizational awareness, psychological commitment needed for effective implementation, understanding, and to improve the quality of the strategic decisions themselves by systematically involving those with specific knowledge and by the obtaining the participation of those who must carry out those decisions. This process involved top management clarifying the overall objectives of the organization, by setting forth broad goals to groups of 'diversification subsystems' and defining the specific criteria those strategy goals should meet.

Each strategic subsystem had its own set of pacing parameters or boundaries, and was responsible for developing further "the architectural details" of goals (p73). Solutions to major strategic problems were rarely full blown, but often partial, tentative, and experimental. Executives guided the strategy process, but let others suggest how best to shape new goals. Indeed, Quinn's (1980) studies showed that effective strategies tended to emerge from a series of discrete strategic formulation subsystems as opposed to formal analytical processes.

Quinn (1980) presented the rationale for using logical incrementalism as a method which assisted top managers to be "politically astute" (p66). The practice of co-opting "valued dissidents" into the strategy formulation process in order to "neutralize" (p119) resistance was also considered by executives to be more helpful than disruptive. It helped create broad conceptual consensus and "risk-taking attitudes" (p27). By avoiding explicitly stated goals or "goal packages" (p66), they reduced the potential for opposition on areas of controversy which only served to draw adverse comments from parochial interests. The "generality" (p72) of broad goals helped promote cohesion by ignoring detailed differences, and instead placed emphasis on widely-held common values relating to individual goals. Adding more

specific dimensions to broad concepts risked complicating communications, losing some individuals' support, and even created conflict at the outset.

Instead of seeking ultimate specificity in the total strategy, effective executives in Quinn's study accepted the ambiguity of the incremental approach. They tried to define the overall strategy in enough detail to encourage people to move in the right directions and to avoid disruptions. But they consciously avoided over-specifics that might impair the flexibility or commitment needed to exploit their information or new opportunities.

Quinn (1980) often extols the merits of such incremental approaches in terms of their political usefulness and effectiveness (p66). For example, he regarded logical incrementalism as "characteristic of good management practice" (pix), and advocated that such approaches were "purposeful, effective, proactive management techniques" (p17). Quinn (1980) dismissed the criticism that logical incrementalism was merely a process of 'muddling through' (Lindblom, 1959), but instead argued that it was a conscious and intentional approach that was practiced by the most effective executives in his study.

Quinn (1980) does warn of some risks attached to this type of integrated approach. Top management could find their strategies thwarted at implementation by failing to accept legitimacy concerns beforehand. They may also be in danger of losing control over the strategy process unless they simultaneously blend consultation, participation, delegation, and guidance to achieve their purposes. Combining these tactics together is a "complex art" (p86), as it presents difficult challenges to those executives who chose to manage strategy differently to more traditional top-down approaches.

To some extent, Quinn's (1980) study reads like an early piece of strategy-as-practice research, as he closely examined how strategies emerge in practice by revealing the practices of executives at a micro-level of analysis through studying what they actually *did* (Johnson et al, 2003). For example, executive's sensitivity to political processes contrasted with prevailing theories of strategic management which emanated from the planning and design schools at that time (Mintzberg et al, 2009).

However, Quinn's study does not award any attention to the role of middle managers when logical incremental approaches were used. All primary data was derived from top management executives, and this tells us little from the perspectives of those strategists out-with top management teams (Balogun et al, 2007). Furthermore, the role of middle managers

exercising managerial agency further down the organization is significantly under-emphasized in favour of 'rationalist' change agency accounts of successful executive practices at the top level (Caldwell, 2006; Whittington, 1992). The emphasis is upon intentional managerial action that, on the whole, produces successful strategic change when logical incremental approaches are adopted.

Vila & Canales (2008) make implicit references to umbrella strategies in their five-year longitudinal study of a Catalonian automobile association which balanced top-down and bottom-up approaches to managing strategic change. This qualitative study aimed to shed light on how both deliberate *and* emergent aspects of strategy-making could be combined to improve the success of change efforts.

The researchers described how a firm consciously changed its approach to strategic management by co-opting middle managers into the planning process as a means of making strategy "relevant" to them (p14), to build commitment, and help them gain a clear appreciation of priorities and goals that would contribute to subsequent co-ordinated action in the implementation phase. The role of top management was redefined and involved "indirect interventions" (p4) once the general direction had been set, as greater emphasis was placed on the strategic role of middle managers.

Setting out the direction for the firm was mainly a centrally-guided effort, but involved "collective deliberation" (p2) in formal and informal discussions between top management, a designated planning centre, and middle managers. The firms approach actively encouraged middle managers to assess the need to deviate from initial plans during implementation as the strategy plan was designed to offer middle managers the flexibility to do so. The researchers highlighted how "planning can create flexibility" (p2), by promoting the use of umbrella strategies as a mean of top management meeting the demands of external factors which influence the strategy, while also awarding greater attention to internal processes e.g. by inviting a wider group of strategic actors to participate and actively shape change.

Vila & Canales (2008) study is important due to the emphasis it places on the critical role of middle managers in "internalizing strategy" (p4), and that their direct involvement in formulation and implementation processes can be highly productive and valuable. The researchers concluded that umbrella approaches can positively influence a firm's prospects for successful implementation, and that the role of strategic planning requires to be reframed less as a means to shape budgetary commitments, but as "a means to set guidelines for

action" (p3). In challenging the role of strategic plans in document form, they also concluded that "what is internalized in the heads of people is more important than what ends up on paper" (p14).

Vila & Canales (2008) study is closely related to the phenomenon of interest of this thesis. By using qualitative methods to carry out a longitudinal study on the interpretative aspects of middle manager strategizing in umbrella contexts, the researchers describe middle manager involvement in strategy-making as a success. However, as the researchers point out, they were not able to trace the direct links between planning and performance, and therefore did not analyse the nature of umbrella strategy outcomes. They also allude to "problems" with the strategy process, but fail to elaborate upon what these problems were (p15). Subsequently, the potential risk or consequences of managerial agency, and how middle managers may have shaped change in an unintended way, is not clear.

In their study of twelve professional organizations across Nordic countries, Mantere &Vaara (2008) identified six discourses which impeded and promoted participation in strategy work. Their aim was to uncover how strategy processes are typically made sense of, and what roles are assigned to organizational members. Three traditional discourses were systematically associated with non-participatory approaches, while three alternative discourses promoted participation. One of these alternative discourses that promoted participation, which the researchers labelled 'dialogization', consisted of umbrella strategy characteristics.

Dialogization includes ideas about collective agency and distributed leadership, and promotes active engagement rather than passive resistance or withdrawal from strategy work. It involves strategic planning as "a dialectic between top-down strategic plans and bottom-up team work and suggestions" (Mantere & Vaara, 2008: p346) whereby bottom-up planning in teams is acknowledged as an important part of the strategy process. Participation is therefore promoted through an integration of top-down and bottom-up approaches.

The dialogical process was characterized by a detailed strategy process where strategic plans, prepared by top management, were transformed into operational plans by the middle managers and operating personnel in the field offices, which were updated and then sent to be processed by the top management team. Strategy was seen as "a collective endeavour" (Mantere & Vaara, 2008: p352) that included all relevant people in the process, and involved a constructive dialogue between different groups. A lack of participation was considered to be "a serious violation" of the very idea of effective strategizing (Mantere & Vaara, 2008:

p352). It included internal *and* external stakeholders, and the right of top management to provide overall guidelines was not questioned as long as these were seen as a meaningful basis for further planning.

Mantere & Vaara's (2008) dialogization discourse is an important acknowledgement of umbrella-type approaches in contemporary strategizing. However, the researchers' data collection was based upon a single data capture period. As they acknowledged, future studies on strategy discourses which are based on longitudinal case designs, and focusing on micro-level interactions, are crucial to better understanding the complexities characterizing contemporary strategizing. There would also appear to be scope to examining dialogization-type discourses in greater depth, as this type of discourse received the least empirical attention in Mantere & Vaara's (2008) study.

Some of the key principles associated with umbrella strategies are also found in Brodwin & Bourgeois' (1984) 'cultural model' for strategy implementation which includes top management guidance and participative elements. While Lovas & Goshal's (2000) model of 'guided evolution' proposes the combination of 'strategic intent' and semi-autonomous administrative systems that offer human and social capital. Central to this approach is that top management guides the evolution of the strategy over time, once the aims and objectives have been set.

On a theoretical level, there are aspects of umbrella strategies which can be conceptually related to complexity theory (Stacey, 1995). Umbrella strategies can be regarded as "complex adaptive systems" that shape emergent order (Campbell-Hunt, 2007: p813). When change develops as emergent strategic activity on the periphery of the organization, it results in 'feedback loops' that, when repeated over time, return to affect the initiating element i.e. the deliberate or planned strategy (Morel & Ramanujam, 1999).

McMillan & Carlisle (2006) advocate complexity-inspired approaches for developing and implementing change as these foster better learning and creativity, and help a wider group of individuals contribute to the strategy-making process. However, Campbell-Hunt (2007) points out that the output of emergent activity can be unpredictable. He also notes that there is considerable risk attached to organization's adopting umbrella approaches, particularly in terms of top management's ability to control the process if the cast of strategic actors increases beyond those at the top level of the organization via the co-optation of multiple actors.

Drawing upon Gidden's theory of structuration (1979), Campbell-Hunt (2007) highlights the role of managerial agency in this process as power becomes diffused in emergent systems. Complexity theory recognizes that autonomous actors shape the flow of emergent strategic activity and that those managerial agents with power (Contu & Wilmott, 2003) can have a "disproportionately large influence" on emergent practices (Campbell-Hunt, 2007: p816). Such concerns resonate with Mintzberg & Water's (1985) point that umbrella strategies' "relax the condition of tight control over the mass of actors in the organization" (p281). Umbrella conditions can subsequently increase the scope for managerial agency (Campbell-Hunt, 2007: p813) and potentially "subvert the original key objectives of the strategy" (Mintzberg, 1994: p196).

However, the creative activities of autonomous actors can also result in 'new routines' that are subsequently formalized and regarded as "emergent accomplishments" (Feldman, 2000: p613). For example, Regner, (2003) described how strategy creation grew out of everyday activities in the periphery of firms (Johnson & Huff, 1997), and in sharp conflict with the centre. Regner (2003) found that managers working on the periphery engaged in different strategic activities than those executives located at the centre's headquarters. This study highlighted how those at the peripheries generated ideas and goals that were subsequently implemented as corporate strategic change in the centre. Despite enduring tension and conflict emerging between managerial groups, the strategic activities undertaken by managers at the periphery of these organizations led to macro-level strategic change.

In summary, despite some acknowledgement of their 'everyday' pervasiveness (Johnson et al, 2008; Mintzberg & Waters, 2002), little remains known about the types of middle managers' practices which accompany umbrella approaches in real-time over extended periods. A research opportunity exists to examine middle managers practices in umbrella contexts, using qualitative methods, on a longitudinal basis, from a micro-level of analysis, and to explore how these practices shape or may be consequential for firm outcomes (Jarzabkowski et al, 2007).

This section has highlighted why umbrella approaches are particularly interesting strategy processes to research on a theoretical level. However, the research agenda in this thesis was primarily driven by the organizational issue i.e. using an umbrella approach to develop and implement strategic change. It was exactly this type of approach that was adopted by the two

public sector organizations involved in this case study which is described in the following chapters.

Balogun et al (2003) have argued for the need for collaboration between strategy researchers and organizational members (p217). In the case study of this thesis, the research agenda between the researcher and the organizations' top management members (who were also the researcher sponsors) was similar, as well as compatible. Although top management did not conceptualize the strategy process by making reference to, or using the terms 'umbrella strategy', 'deliberately-emergent', 'logical incrementalism', 'guided evolution', or 'dialogization', it was, by definition and in practice, what they were doing.

This section has also highlighted that there are a number of areas which middle managers' practices in umbrella contexts can be considered from, whether theoretically or practitioner-led, or both. This thesis is specifically interested in middle managers' practices which explore the legitimacy and commitment dimensions of deliberately-emergent approaches to strategic change, and the following section explains why.

2.4 Gaining legitimacy and attaining commitment in strategic change

Strategy researchers place considerable importance on the concepts of legitimacy and commitment in the strategic change process, and both concepts are frequently cited across the strategy literature.

It is acknowledged that gaining legitimacy for strategic decisions is difficult and critical to the strategy process, especially where attempts are made to initiate and sustain strategic change (Gioia et al, 1991; Neilsen & Rao, 1987; Pfeffer & Salancik, 2003). Researchers have noted that the presence of legitimacy is essential for successful strategic change, whilst its absence can lead to strategy failure (Suchman, 1995). Pfeffer & Salancik (2003) have highlighted, "legitimacy may be a problem when an established organization begins new or different activities…especially if the new activity is really something quite different and not an imitation of something already being done" (p203). Consequently, organizations can face "justification problems" as they seek understanding and acceptance of new strategies (Fiss & Zajac, 2006: p1174).

Legitimacy is widely considered by strategy researchers to be a product of the social construction processes of stakeholders' evaluations of organizations and its activities (Ashforth & Gibbs, 1990; Deephouse & Carter, 2005). As Pfeffer & Salancik (2003) state,

"For the organizational strategist…the socially constructed nature of legitimacy is an important feature" (p194). Many strategy researchers agree that legitimacy is fundamentally "a social judgement" (Ashforth & Gibbs, 1990: p177) founded on a process of "the making of meaning" (Neilsen & Rao, 1987: p523).

As legitimacy is widely regarded as something which is socially constructed, creating understanding and meaning can be difficult (Ashforth & Gibbs, 1990; Berger & Luckmann, 1967; Kelman, 2001; Meyer & Rowan, 1977; Neilsen & Rao, 1987; Scott, 2001; Suchman, 1995; Zelditch, 2001), because managing actors' interpretations of organizational activities can be complex (Bartunek, 1984; Gioia et al, 1991; Johnson & Balogun, 1998), as what constitutes being legitimate can be conflicting and vague for organizational actors (Elsbach & Sutton, 1992; Jarzabkowski, 2005; Meyer & Rowan, 1977).

Legitimacy attainment within strategic change can be difficult because the legitimacy that is required at a regulative level may be in conflict on a normative level (Scott, 2001). Strategies driven by regulative coercive pressures (DiMaggio & Powell, 1983; Meyer & Rowan, 1977) that are not congruent with actor's normative evaluations may present a problem for organizations as professional actors are known to adhere to normative standards (Kelman, 2001) which may clash with the "mere legal requirements" expected of the organization (Scott, 2001: p61). Furthermore, legitimacy may not be strictly based on value congruency and normative evaluations. Hirsch & Andrews (1986) distinguish between 'performance' and 'value challenges,' as organizations are open to "performance challenges when they are perceived as having failed to execute the purpose for which they claim support" (p173).

The type of legitimation processes which are subsequently deployed to influence others are considered as critical from a cognitive and procedural justice perspective (Bareil at el, 2006; Brockner, 2002; Fiske & Taylor, 1991; Lind & Tyler, 1988; Thibaut & Walker, 1975). Actors are less likely to make positive evaluations and to comply with authorities if top management have failed to ensure procedural justice (Tyler, 1990; Tyler et al, 1997). Therefore, being able to gain voluntary acquiescence from change recipients increases effectiveness (Tyler, 2006).

It is argued in this thesis that actors are not passive consumers of legitimation practices but active evaluators of organizational activity (Ashforth & Gibbs, 1990: Giddens, 1991; Jarzabkowski, 2005; Neilsen & Rao, 1987). Radical change does not simply go unnoticed, but is instead frequently open to new legitimacy demands (Bartunek & Moch, 1987; DiMaggio, 1988). Furthermore, new practices which are required to support change can take

time before they are institutionalised and taken-for-granted, as they are rarely mandated as soon as they are proposed (Scott, 2001).

This thesis follows Weber's (1918/1968) and other researchers' arguments that power or legitimate authority alone is not sufficient to legitimate an act, but instead emphasize the role of social influence (Fiss & Zajac, 2006; Massey et al, 1997; Ridgeway et al, 1995; Tyler, 2006; Zelditch, 2001b). Shaping behaviour effectively through coercive mechanisms is not effective in the long-term as coercive approaches require enormous resources to create a credible system of surveillance through which to monitor behaviour and punish rule violators (Tyler, 2006). Therefore, alternatives to coercive power need to be considered by those in top management teams when attempting to influence their employees (Tyler, 2006).

Attempts to establish legitimacy are a key part of management (Ashford & Gibbs, 1990; Dowling & Pfeffer, 1975; Vaara et al, 2006), but attempts to foster legitimacy create a managerial dilemma with regards to issuing directives versus allowing actor's participation and managing consent (Eden & Ackermann, 1998; Floyd & Wooldridge, 1992; Mantere & Vaara, 2008). This issue has particular resonance with respect to umbrella strategies (Mintzberg & Waters, 1985).

Finally, even if legitimacy for strategic decisions are considered by top management to have been acquired, it cannot be considered as 'stable' during the strategy process. Pfeffer & Salancik (2003) identify this issue as "problematic, because the definition of what is legitimate is continually changing and evolving, partially in response to the actions taken by organizations" (p201). As the salience of one or another legitimacy assessment may vary over time and place (Dacin, 1997), legitimacy is always temporal because what is considered legitimate at one point in time can change (Ruef & Scott, 1998).

In the strategic change and HRM literatures, commitment is also acknowledged as something that is difficult to develop in practice. Both sets of literatures view commitment as something that requires to be created, developed, or 'won' (Argyris, 1998; Balogun & Hope-Hailey, 2004; Barney, 1991; Beech, 2000; Beer & Walton; 1990; Beer et al, 2000; Brooks & Wallace, 2006; Chawla & Kelloway, 2004; Dooley et al, 2000; Guest, 1987; Iles et al, 1990; Iverson, 1995; Jarzabkowski & Sillince, 2007; Johnson et al, 2008; Korsgaard et al, 1995; Kotter, 1995; Laine & Vaara, 2007; Mantere & Vaara, 2008; McElroy, 2001; McKenzie et al, 2001; McMillan & Carlisle, 2006; Pfeffer, 1998; Redman & Snape, 2005; Rousseau, 2001; Salancik, 1977; Shapiro, 2003; Walton, 1985).

These sets of literature have gradually given more attention to the concept of commitment and the importance of 'commitment-building' (Fiorelli & Margolis, 1993; Lines, 2007; McKenna & Beech, 2002; Pettigrew, 1987; Pugh, 1993; Shapiro, 2003). Piderit (2000) argues that this is because successful organizational adaptation is increasingly reliant on generating employee support and enthusiasm for proposed changes, rather than merely overcoming resistance. Fiol (2001) highlights the need for firms in highly competitive environments, or non-stable environmental cultures, to nurture employees' ability to continually re-identify with new strategic goals, and to be competent in shifting employees' commitment towards continuous organizational changes.

Gaillie et al (2005) note a change in the central objective of UK management practice since the 1990's as shifting from a 'control to commitment' mode (Walton, 1985), while Cartwright & Holmes (2006) argue that greater attention to employee commitment has been necessary because the demands placed on employees in modern work contexts have significantly increased. As a result of these demands, employees have gradually developed cynical attitudes and become more mistrusting of their employers which present additional challenges to organizations when new initiatives are proposed.

Commitment to change can be dependent on trust between top management and implementers (Fiorelli & Margolis, 1993). The commitment and support of top management is widely regarded as essential to successful implementation (Balogun & Johnson, 2004; Darragh & Campbell, 2001; Eden & Ackermann, 1998; Gill, 2003; Hambrick & Cannella 1989). However, the strategic change and HRM literatures tend to place more emphasis on the process of 'winning the commitment' of those outside top management teams (Shapiro, 2003) and advocates top managers actively "mobilize commitment to change" (Beer et al 1990: p161).

Commitment is considered to be vital to the strategy process because it positively influences firm performance (Bowman & Ambrosini, 1997; Dess & Priem, 1995). Ackermann & Eden (2005) argue that an organization changes as a result of the commitment and energy of the people within in to make changes, and high levels of commitment are considered to be essential for the effort, initiative, and cooperation that coordinated action demands (Beer et al, 1990).

The consequences of failing to gain commitment to change are significant. Without committed employees, the implementation of any new initiative is seriously compromised

(Argyris, 1998). Hafsi (2001) found that losing the willingness of key employees towards implementation can defeat the very purpose of change. Similarly, Hickson et al (2003) found that unless those who are affected by strategic change are committed to implementation, success is much less likely. While Lynch (2003) suggests that people who have not been involved in the development of the strategy are less likely to be committed to it.

The normative view in the strategic change and HRM literatures suggests that committed employees are considered to be more productive and more adaptable to change (Beer et al, 2000; Guest, 1987; Huselid, 1995; Kotter, 1995; Pfeffer, 1998; Salancik, 1977). This view has developed in parallel with the emergence of strategic human resource management practices, and the resource-based view of the firm in the strategy field (Barney, 1986, 1991; Helfat, 2000; Teece et al, 1997; Wright et al, 2001).

The resource-based view (RBV) proposes that highly committed employees can optimise organisational performance for competitive advantage and can help firms successfully execute their strategies (Lado & Wilson, 1994; Pfeffer, 1998). Empirical studies have shown that systems of 'high commitment' human resource practices increases organizational effectiveness by creating the conditions where employees become highly involved in working to accomplish the organization's goals (Arthur, 1994; Wood & de Menezes, 1998).

The RBV focus on the internal organization of the firm evolved in response to the traditional emphasis of strategy researchers on industry structure and strategic positioning as the key determinants of competitive advantage (Gibbert, 2006). The RBV expressed concerns that those from the positioning school (Porter, 1980, 1985) failed to draw enough attention to the gulf that existed between strategy conception and effective execution (Barney, 1991; Lee & Miller, 1999; Teece et al, 1997; Wernerfelt, 1984).

Barney (1986, 1991) proposed that sustained competitive advantage derives from the resources and capabilities a firm controls that are valuable, rare, imperfectly imitable, and not substitutable. In explaining why some firms outperform each other, RBV research has focused on firm 'idiosyncratic resources' (Barney, 2001; Gibbert, 2006). Resource-based theorists conclude that the main reason firms vary in performance is that they differ in human capital (Hitt et al, 2001), and it is the human capital of the organization - in the form of a committed workforce - which serves as the most valuable resource for the success of strategy execution (Barney, 1986; Boxall, 1998; Fiol, 1991; Lee & Miller, 1999; Wright et al, 1995).

An objective of the RBV is to identify how firms can exploit their human capital (Barney, 2001), and the concept of commitment has been identified as a key human resource which supports successful strategy implementation (Lee & Miller, 1999; Wright et al, 2001). Yet at the same time, the RBV acknowledges that this resource is one which is both intangible and socially complex, hence making it difficult to create (Barney, 1991; Hitt et al, 2001).

The message from resource-based theorists is confusing, yet not uncharacteristic of the conflicting and ambiguous advice which the field of strategy research has drawn criticism for (Johnson et al, 2003; Tranfield & Starkey, 1998; Whittington et al, 2004). The concept of commitment as a key human resource to support successful strategy execution raises an important question from a strategy-as-practice perspective (Johnson et al, 2008). How can managers actually exploit, manipulate, or develop change recipient commitment as a resource in a practical sense, when its intangibility, elusiveness, and complexity are so pervasive?

Although theoretically insightful, the resource-based position does not fully explain which detailed managerial practices or activities enable the attainment of actor's commitment to change. This can be attributed to its emphasis on large-scale statistical studies which have excluded the detailed practices of employees that produce value to firms (Johnson et al, 2003; Shimizu & Armstrong, 2004). The RBV does highlight the difficulties that managers face when attempting to gain change recipient commitment (Wright et al, 2001), but it offers little advice in the form of practical guidelines beyond its repeated emphasis on the importance of 'building-commitment' (e.g. Barney, 1991, 2001; Hitt et al, 2001).

These criticisms of the resource-based view's position on attaining commitment are consistent with those wider criticisms from a strategy-as-practice perspective which cite problems with the 'generalities' and lack of practical detail which the RBV is prone to offer practitioners (Ambrosini et al, 2007; Golsorkhi et at, forthcoming; Johnson et al, 2003; Priem & Butler, 2001). Management researchers have therefore continued to call for more studies which identify the key factors that influence individual level commitment to implementation (Hrebiniak, 2006; Noble, 1999; Pelligrinelli & Bowman, 1994; Shapiro, 2003).

In summary, the challenge of gaining legitimacy for strategic decisions and attaining actor's commitment to implementation are acknowledged as important issues in managing strategic change successfully. However, some researchers have gone further by claiming that there are

important links between legitimacy and commitment which have implications for strategy outcomes.

For example, the strategy literature describes the aspiration of top management to attain actor's commitment to managerial espoused change targets (Balogun & Hope-Hailey, 2004; Johnson et al, 2008; Mantere & Vaara, 2008), and to achieve this they should foster legitimacy for strategic decisions in order to secure actor's commitment (Ackermann & Eden, 2005; Barney, 1991; Beer et al, 1990; Brown, 1998; Quinn, 1980). Therefore, where legitimacy is gained, this infers commitment to the strategy. Some researchers have also argued that where commitment is gained, this infers legitimacy for the strategy (Dooley & Fryxell, 1999; Human & Provan, 2000; Nutt et al, 2000; Pfeffer, 1981; Stone & Brush, 1996).

A range of examples that are representative of these viewpoints, which has gradually come to form a normative view in the literature that there is a reciprocal relationship between gaining legitimacy and attaining actor's commitment, which will support successful strategic change, are offered below. All of these particular arguments resonate with the Aristotle-based view that legitimacy is dependent on consent. Therefore, commitment to change is dependent on consent towards it, and that actor's commit to what is perceived as 'just' (Zelditch, 2001b), 'proper' or 'appropriate' (Suchman, 1995).

Tyler & Blader (2005) propose that employees are more willing to follow organizational rules and authorities when they believe that they are legitimate, while Dess & Priem (1995) highlight the importance of consensus in promoting a unified direction for firms, which increases strategic commitment and enhances the successful implementation of a given strategy. Human & Provan's (2000) study of legitimacy within multi firm business networks concluded that the acceptance of new business networks by internal and external groups resulted in "cognitive support and commitment" (p328). Pascale & Athos (1981) found that the high levels of consensus characteristic of Japanese decision-making processes resulted in highly committed implementation efforts that accounted for the ability of Japanese firms to swiftly implement decisions. Quinn (1980) found that legitimizing viewpoints and creating pockets of commitment were, together, both processes which are central to effective strategic management.

Dooley & Fryxell (1999) have argued that commitment plays a mediating role between consensus and implementation outcomes, as consensus leads to commitment by increasing the belief that individual effort will lead to implementation success. Lines (2007) points out

that a lack of consensus is threatening to implementation because organizational members are unlikely to become committed to decisions about which they disagree (p150). Godard (1999) suggests that ideologically driven changes are likely to achieve higher levels of support and commitment from key managers. Argyris (1998) argues that individuals become committed to projects based on their own reason or motivations, while Mantere & Vaara (2008) propose that cynical attitudes have broader implications in undermining the legitimacy of certain approaches to strategy.

Ackermann & Eden (2005) argue that actor's commitment to strategy delivery is dependent upon the legitimacy of the strategy-making process and procedures used to develop it. Nutt (1998) reported that actors become more committed to implementation when they participated in decision-making processes than when they did not, while Novelli et al (1995) maintain that justice concerns about organizational change influence employee's commitment towards it.

Brown (1994, 1995, 1998) notes how organizational leaders tend to be aware of the importance of fostering legitimacy for their strategies, which helps secure employee acquiescence, enthusiasm, and commitment. Chakravarthy & Garguilo (1998) highlight how the degree of commitment and support that can be generated from internal stakeholders during organizational restructuring is dependent upon on the organization leaderships' own social legitimacy. Howell & Higgins (1990) and Hammer & Turk (1987) found that top management commitment towards middle managers increased the legitimacy of the latter group. Legitimacy gave middle mangers the authority to define goals for their business units, which increased their understanding of what was possible for them to achieve (cf. Mantere, 2008: p18).

In addition to the above examples, two separate research studies have directly attempted to elaborate further on the legitimacy-commitment relationship (Dooley, Fryxell & Judge, 2000; Stone & Brush, 1996). Dooley et al's (2000) study examined the relationship between strategic decision consensus and implementation success. Initially, they argued that there was little empirical evidence that decision consensus actually leads to decision implementation success. Their results confirmed their hypothesis that decision commitment would increase the likelihood of implementation success. The more committed the decision-making teams to the strategic decision, the greater the likelihood of the decision being implemented successfully.

Their findings showed that decision consensus appears to result in subsequently higher levels of commitment to the strategic decision among members of the decision-making team. Moreover, they found that this commitment, once engendered by consensus, was positively related to successful decision implementation. Their results supported "the normatively accepted ideal" that decision consensus helps build decision commitment, which in turn positively affects implementation success (p1237).

Dooley et al (2000) concluded that their study provided "empirical verification of the normatively accepted, but seldom examined, belief that consensus as an outcome of the strategic decision-making process promotes commitment, which in turn increases the probability of implementation success" (p1254). In acknowledging the limitations of their quantitative methodology, Dooley et al (2000) recommended that additional insight would be gained with in-depth qualitative studies that track specific strategic decisions from formulation through implementation.

There are also a number of methodological issues which raises questions about the reliability of their data to support claims of reciprocity. A research questionnaire survey was initially mailed to the CEO's of 450 US hospitals, who were responsible for nominating further questionnaire participants. The researchers had little control over targeting their sample, and were reliant on the CEO identifying suitable participants. Decisions that were considered to be of strategic significance were also determined by the CEO and not by other actors in the organization.

Quantitative data was then gathered over three separate data collections periods (month 1, month 2, and month 20). However, the researchers were not able to rely on the same respondents from each of the 68 hospitals who remained involved in the study at month 20. Different respondents participated at different points in time to the initial strategic decisions identified by their CEO's. These multiple discrete decisions did not cover the same single organization, or group of organizations, due to subsequent drop-out rates. The inconsistencies in their longitudinal data collection methods question the strength of the data used to reaffirm reciprocity. For this reason, the researchers stated that they were not confident about being able to generalize their results across "more typical business contexts" (p1253), and that issues relating to consensus, commitment, and implementation success may play out differently in other organizational contexts.

Stone & Brush (1996) focused on the pressures that top management face to gain commitment and meet the demands for legitimacy within strategic planning cycles. They examined different types of planning practices to develop an understanding of the relationship between commitment, legitimacy, and planning, and how these practices contributed to resource acquisition.

Prior to establishing the relationship between all three variables, Stone & Brush (1996) first addressed the relationship between commitment and legitimacy. They argued that although the concepts of commitment and legitimacy are distinct, they interact. How the relationship is manifested from Stone & Brush's (1996) perspective concerns actor's commitment to the strategic planning process, on the basis that actor's believe their firms either possess, or will gain, organizational legitimacy.

For example, "Commitment operates at the individual level while legitimacy derives from external groups. For individuals to become 'members' or participants in an organization, they must believe that the organization is legitimate….conversely, legitimacy is unlikely without evidence of commitment" (Stone & Brush, 1996: p634). The relationship therefore is reciprocal on the basis that top managers commit to participating in planning process if they believe that their firm holds organizational legitimacy[3].

Organizational legitimacy from external constituents is unlikely to be granted if there is no evidence of [internal] commitment from management towards strategic planning. Internal managerial commitment and external legitimacy are both required for organizations to acquire resources to compete or survive (p634). Stone & Brush (1996) suggest that managerial commitment to producing written plans helps gain access to resource suppliers and gain legitimacy through external validation (Dowling & Pfeffer, 1975).

On a managerial practice level, Stone & Brush (1996) suggest that managers need to use informality and social interaction to build commitment by creating shared perceptions and obligations, while simultaneously demonstrating goal-orientated action and the use of formal systems to acquire legitimacy from critical resource suppliers.

On a planning level, they propose that non-profit organizations and entrepreneurial firms often face conflicting [internal] commitment and [external] legitimacy pressures, which can

[3] The issue of whether legitimacy is purely an external macro-level phenomena which Stone & Brush (1996) and many institutional and resource-dependence theorists claim it to be is discussed in Chapter 3 (Section 3.1.3)

produce different patterns of 'sequencing' in planning processes i.e. interpretative planning, abbreviated planning, decoupled planning, and formal planning. The outcome of Stone & Brush's (1996) work is the development of a planning configuration framework to help firms adopt different types of planning cycles. The use of one type over another ought to be contingent upon the type of commitment and legitimacy pressures faced by firms operating in ambiguous contexts (p646).

Stone & Brush (1996) produce an interesting planning contingency model which draws upon the concepts of commitment and legitimacy. Unlike Dooley et al's (2000) study which offers empirical data to support claims of reciprocity, Stone & Brush (1996) offer a number of theoretical propositions around the relationship between planning, commitment, and legitimacy. Their focal emphasis is upon the role of planning and deliberate strategizing, and not how commitment and legitimacy interact in relation to strategic change, or where deliberate planning *and* participative emergent approaches are used simultaneously. Furthermore, their study is strongly top management-orientated, with no reference to how middle managers fit into the strategic planning process.

Where the concept of legitimacy is highlighted in strategy studies, it is not uncommon for the concept of commitment to follow, and vice versa. However, those researchers who claim that there is a reciprocal relationship between legitimacy and commitment are often vague about how legitimacy is fostered in practice, and how actor's commitment is gained as a consequence. The research gaps around this issue are significant from a strategy-as-practice perspective, as the normative view leaves a number of questions unanswered.

First, little research exists at the micro level of analysis which draws upon the narratives of those outside of top management teams whose legitimacy and commitment is being sought (Balogun et al, 2007; Johnson et al, 2003). How middle managers confer legitimacy to strategic decisions (Laine & Vaara, 2007), and how they develop the commitment sought by top management to put those decisions into action, has not been explored (Hbreniak, 2006; Mantere, 2007). Little remains known about the practices of middle managers when evaluating the legitimacy and commitment dimensions of strategic change (Balogun et al, 2007; Mantere & Vaara, 2008; Melin, 2007; Reckwitz, 2002; Vaara, 2004), especially in terms of *the basis* of why they confer legitimacy and commit to a particular course of action (O'Reilly & Chatman, 1986; Suchman, 1995).

Second, the legitimacy-commitment relationship has not been examined within the context of an umbrella strategy (Mintzberg & Waters, 1985). Any analysis on how middle managers confer legitimacy and how they develop commitment sought by top management must take cognisance of the organizational and institutional context within which those actors are situated (Balogun, 2006; Burgelman, 1983; Johnson et al, 2008; Pettigrew, 1987; Pettigrew et al, 2002; Salancik, 1977). As Whittington (2006) has argued, "contextualization of micro-activities and an appreciation of wider contexts [in which they occur] can help make intelligible many of the complex details revealed by intimate investigations" (p617).

An observation from reviewing those legitimacy and commitment studies which relate to strategic change is that they too often fail to recognize the importance of context when analyzing strategic change. For example, where organizations are situated in modern, complex, or diverse strategic contexts that involve implementing multiple goals (Jarzabkowski & Sillince, 2007), or operating in pluralistic settings (Denis et al, 2001).

It is argued in this thesis that, in addition to the organizational and institutional context within which practitioners strategize (Johnson et al, 2007), the 'strategic context' in which actors evaluate issues of strategy legitimacy and strategy commitment may also be of theoretical importance. For researchers to analyze actors' legitimacy and commitment evaluations during the strategy change process, without taking into account the "intra-organizational" strategic context or the approach to strategic change that is adopted by the organizations in which those evaluations occur (Whittington, 2006: p627), places major limitations upon any findings which are generated from an analysis of the legitimacy-commitment relationship. To do so, would simply be following the path of the processual tradition, which strategy-as-practice researchers have criticized for placing too great an emphasis on detailed descriptive studies that solely focuses on the emergent, micro-level aspects of managerial activity without acknowledging the formal aspects of the strategy process, or the wider social context in which that activity actually takes place (Johnson et al, 2003; Whittington, 2004, 2006).

Third, little is mentioned in relation to how top managers should address the problems of fostering legitimacy and gaining commitment to strategic change in a practical sense. There has been a lack of meaningful, practical guidance offered to practitioners with respect to this managerial issue (Golsorkhi et al, forthcoming; Johnson et al, 2007). Namely, whether the simultaneous fostering of legitimacy and attainment of actor's commitment is "actually manageable" (Johnson et al, 2003: p15). If it is, 'how so?', as these aspects of managerial

activity - such as the practice of fostering legitimacy and attainment of actors' commitment - has major implications for strategy performance and strategy outcomes (Johnson et al, 2003).

2.4 Chapter summary

This chapter has provided a review of the strategic change literature and highlighted those problems commonly associated with implementing change, as well as listing those managerial practices which impact on change outcomes. In particular, it draws attention to the importance that strategy researchers place on the concepts of legitimacy and commitment, which suggests that they are both considered to play a significant role in the strategic change process.

It has also highlighted that some researchers suggest there is a reciprocal relationship between both legitimacy and commitment, which in turn, supports successful strategic change. Although claims of reciprocity between legitimacy and commitment in strategic change are questioned within this thesis, it is argued that the current usage of legitimacy and commitment concepts that are employed to support claims of reciprocity is fundamentally problematic from a discursive perspective, because legitimacy and commitment are multifaceted constructs and not one-dimensional as the strategic change literature is prone to inferring.

The strategy literature tends to cite legitimacy and commitment in very general terms. This lack of conceptual clarity is an issue which some legitimacy and commitment researchers have been highly critical of (Meyer & Allen, 1997; Suchman, 1995). Vaara et al (2006) have noted "significant ambiguity concerning what legitimacy actually means" in studies on strategy and legitimacy (p580). The generic use of 'legitimacy' within strategy research has invited the questions, "legitimacy for what?", "from whom?" and "on what basis?" (Parsons, 1960; cf. Pfeffer & Salancik, 2003: p24).

Similarly, many broad conceptualisations of commitment are found in the strategy literature[4]. These are often vague and non-specific about what *type* of commitment is being sought e.g. behavioural, attitudinal, or both. Furthermore, the strategic change literature is often unclear

[4] Some strategy researchers are more specific than others about what type of commitment they are referring to. For example, Ackerman & Eden (2005) make specific reference to 'emotional commitment' and 'cognitive commitment' (p199). Balogun & Hope-Hailey (2008) refer to 'emotional commitment', and Quinn (1980) refers to 'psychological commitment' (p90). However, these examples are more the exception than the rule.

about whether organizations that seek commitment from its members are seeking commitment to 'the organization' or commitment to 'the strategy'.

Meyer & Allen (1997) point out that commitment is a complex multifaceted construct and have called for "acknowledgement of the differences in how the concept of commitment is used prior to its application in research to prevent further confusion and ambiguity regarding its use" (p15). However, to date, this call has not been seriously addressed within the strategy field. It is argued that poor conceptual clarity around legitimacy and commitment constructs within strategic change discourse is likely to remain unhelpful to both strategy researchers and practitioners.

The following chapter explores in greater detail how the concepts of legitimacy and commitment are applied within the wider strategy and management discourse, prior to establishing two working definitions for this thesis: 'strategy legitimacy' and 'strategy commitment'.

CHAPTER 3

LEGITIMACY AND COMMITMENT WITHIN STRATEGY & MANAGEMENT DISCOURSE

Introduction

The purpose of this chapter is to examine more closely how legitimacy and commitment are conceptualized theoretically and applied empirically across the strategy and management literature. From a strategy-as-practice perspective, providing such conceptual clarity is an important issue. Practice researchers have been encouraged to ensure that the concepts they offer to practitioners, and the field of strategy research as a whole, are explicit and unambiguous as opposed to being vague and abstract (Golsorkhi et al, forthcoming; Johnson et al, 2007). It would be problematic to begin examining the legitimacy-commitment relationship without first providing conceptual clarity around both constructs. This view is shared by prominent legitimacy and commitment researchers.

For example, Suchman (1995) argues that, "researchers who study legitimacy either should address the full range of the phenomenon or should clearly identify which aspect(s) they have in mind…[as] such care might go a long way toward quelling unproductive debates over the operationalization of legitimacy in specific studies" (p602). While Meyer & Allen (1997) have stated, that "it is incumbent upon researchers to be explicit in their definitions of commitment" because "from a scientific standpoint, we cannot begin to study the development and consequences of commitment systematically until the construct is defined and measures are developed…as practitioners will have difficulty taking guidelines from the scientific literature…until we clarify what we mean by commitment" (p11).

This review of the legitimacy and commitment literature will illustrate that there are different forms of legitimacy which contrast with each other (Hegtvedt & Johnson, 2000; Jarzabkowski, 2005; Scott, 2001; Suchman, 1995) and multiple commitment constructs which are not all alike (Becker, 1992; Mathieu & Zajac, 1990; Meyer et al, 1993; Reichers, 1997). The implication of which is, that these different forms of legitimacy and commitment may potentially have very different relationships to each other. This chapter is divided into two sections:

i. legitimacy in strategy discourse

ii. commitment in strategy discourse

3.1 LEGITIMACY IN STRATEGY & MANAGEMENT DISCOURSE

With Suchman's (1995) argument in mind, this section presents the theoretical development of legitimacy, reviews how current conceptualizations of legitimacy are applied across the strategy and management literature through various legitimacy frameworks, and it identifies how external and internal sources of legitimacy help distinguish between *organizational legitimacy* and *strategy legitimacy* as separate constructs for analysis when studying legitimacy and strategic change. The section concludes by establishing a working definition of 'strategy legitimacy'.

3.1.1. The theoretical development of legitimacy

Issues of legitimacy have historically been concerned with those at the societal and institutional level (Meyer & Rowan, 1977; Tyler, 2006). In an overview of the chronological development of theories of legitimacy over the last twenty-four centuries, Zelditch (2001a) argues that contemporary thinking about legitimacy remains framed by early Greek thought, hence acquiring its status as "one of the oldest problems in the intellectual history of Western civilization" (p33). Zelditch (2001a) first points to Thucydides' (423 BC) Melian Dialogues from the Peloponnesian War, when Athens offered the island of Melos the alternatives of voluntarily submitting to Athenian rule or being destroyed. These dialogues consisted of Athenian justification of its powers versus the Melian justification of its resistance.

Zeldtich (2001a) noted the problem of legitimacy of coercive power did not go away for the early Greeks (p36), and states it was this problem that Plato's *Republic* (ca. 390 BC) and Aristotle's *Politics* (ca. 335-323 BC) were written to solve. In the former, Socrates' dialogue with Thrasymachus in Book 1 of *The Republic* raises the argument that 'might does not make right', while Aristotle was concerned with what makes the constitution of a state 'just'. Aristotle also questioned the legitimacy of government, which he saw as dependent on constitutionalism and consent, and considered injustice to be the cause of revolutions. A theory of political stability emerges from Aristotle's *Politics*, as well as a theory of distributive justice in which rewards were only 'just' if they were proportional to contributions (Zelditch, 2001b). Political stability and distributive justice were considered as perpetually problematic and dominated theories of legitimacy for many centuries (Zelditch (2001a: p36).

A prolonged gap in the theoretical development is evident by the fact that it was not until the sixteenth century that Machiavelli (1517 / 1940a, 1532 / 1940b) argued that political stability depended directly on the legitimacy of government itself. Machiavelli contended that pure power is impotent because its stability depends on voluntary acceptance, and voluntary acceptance depends on legitimacy. The issue of consent was central to Locke's (1690 / 1960) view of what ought to be the basis of a government's legitimacy, whilst Rousseau's social contract theory (1762 / 1948) not only reiterated earlier Machavellian themes on acceptance depending on legitimacy, but also that managing consent was a function of the legitimacy of government itself. Zelditch (2001a) summarised the central dilemma of these early theoretical debates by concluding, "The problem of any kind of polity….is to find a basis of loyalty that is voluntary but not purely instrumental, that does not depend only on rational self-interest or purely on personal preferences" (p37).

Attention shifted from classical or power-orientated theories of legitimacy because the purely instrumental foundations of political stability were rejected and theorists began to focus instead on legitimacy from two theoretical positions: consensus theory and conflict theory (Zelditch, 2001a: Tyler, 2006). This shift is significant because it suggests an interest in the macro societal-level aspects of legitimacy, moving towards the meso field and organizational-levels, and more importantly, towards the micro individual-level.

Proponents of consensus theory broadened the focus of legitimacy to include features other than power systems (Lipset, 1959; Parsons, 1958, 1960; Rousseau, 1762/1948) and draw heavily on Aristotle's *Politics*. Parsons (1958 / 1960) describes consensus theory as consisting of (a) acceptance of a social order as voluntary; (b) consent being based on belief in (as distinct from instrumental orientation to) norms and values; (c) rulers and the ruled alike sharing the same norms, values, and beliefs; (d) it is either consensus, or in some consensus theories, the group interest (e.g. Rousseau, 1762 / 1968) that make norms and values "right", hence "legitimate"; and (e) a social or political order is stable if, and only if, it is legitimate (cf. Zelditch, 2001a: p41).

In contrast, Machiavelli's (1517 /1940a, 1532 / 1940b) conflict theory assumes that (a) the fundamental basis of both action and order is instrumental and governed by rational self-interest; (b) the real interests of the rulers and the ruled are in conflict; and (c) it is power that makes the rules binding. Machiavelli also argues that pure power cannot make people believe that a rule is "right" by masking the real interest of the rulers and the ruled, and in the long

run, pure power is unstable unless legitimated, so legitimacy is a prerequisite of any social order.

The main distinctions between conflict and consensus theories are summarized by Sidanius et al (2001) by discriminating "the role of power in making the rules…not the role of consent" (p43). However, there are elements of Parsons' (1956) consensus theory which seem idealistic and naïve as it suggests that organizations can achieve harmonious stable states through unilateral agreement and consent among all actors or stakeholders (Knights & Morgan, 1993). Conversely, conflict theory risks creating a portrayal of organizations as aggressive confrontational arenas, and depicts organizational life as perpetually hostile where all decisions and practices are contested (Clegg & Haugaard, 2009).

It is argued that framing legitimacy within the strategy change process in such a dichotomous way as being either conflictual or based on consensus has its limitations. Adopting 'a mixed strategy' of legitimacy such as that proposed by Weber (1918/1968) offers a better reflection of the complexities often associated with the strategic change process (Campbell-Hunt, 2007; Jarzabkowski, 2005), because it recognizes elements of both consensus (Bowman & Ambrosini, 1997; Floyd & Wooldridge, 1992; Zelditch & Floyd, 1998) and conflict (Bacharach et al, 1999; Ezzamel et al, 2001; Gray & Ariss 1989; Pettigrew, 1985).

Weber is widely regarded as the most influential social theorist to stress the importance of legitimacy (Ruef & Scott, 1998; Scott, 2001; Suchman, 1995; Tyler, 2006). He extended conflict and consensus theories by developing a 'mixed strategy' which is neither a consensus nor a conflict theory, but comprises a complex mix of the two[5]. Weber was particularly concerned about the *sources of legitimacy*. He distinguished between legitimacy [of authority] based upon deference to customs and values (traditional authority), legitimacy based upon devotion to the actors or character of an authority (charismatic authority), and legitimacy linked to the process of rule creation and interpretation (rational bureaucratic authority). Weber's work makes clear that the legitimation of authority and institutions

[5] Other 'mixed strategy' theories of legitimacy are also offered by Gramsci (1947/1971) and Habermas (1975), however, these arguably adopt a more macro-level orientated perspective. Gramsci's central concept of 'hegemony' combines coercive repression and control by ideological leadership and persuasion to produce consent, and he places emphasis on 'ideological superstructures' which are relatively autonomous but dominate and influence subordinates. Hegemony is achieved through "cleverly masked domination" (Brown, 2005: p1582) where subordinates are reliant on others to inform them and help them understand the social world as they are unable to do so themselves because they "do not actively participate in creating or critically assessing the philosophies that guide their lives" (Ives, 2004: p79). Like Gramsci, Habermas also draws on elements of Marxist theory and is concerned with the relationship and contradictions between 'base and superstructure' (Zelditch, 2001a).

through “the rule of law” is only one of many ways in which social arrangements might be justified, and is not simply a matter of which group(s) benefits from conflict, nor the achievement of unilateral consensus (cf. Tyler, 2006).

The theoretical development of legitimacy can also be found in organizational theory, and the concept is closely associated with institutional theory (Zelditch, 2001a). Institutional theorists highlight that organizations are prone to developing isomorphic tendencies, and a central proposition of institutional theory is that isomorphism leads to legitimacy (DiMaggio & Powell, 1983, 1991; Meyer & Rowan, 1977; Scott, 1987, 2001; Zucker, 1987). Organizations seek legitimacy by incorporating structures, values, norms, and expectations of constituents that match widely accepted cultural models embodying common beliefs and knowledge systems. The pursuit of similarity is driven by the need for congruency between the organization and its cultural environment (Meyer & Scott, 1983). This is manifested via formality, offices, specialized functions, rules, records, routines and guided by prescriptions from the institutional environment (DiMaggio & Powell, 1991). These attributes serve as powerful but subtle myths of why organizations ought to exist and how they ought to function (Meyer & Rowan, 1977).

Although DiMaggio & Powell (1983) also reinforced this emphasis on institutional isomorphism, by focusing attention on coercive, normative, and mimetic mechanisms, they argued “isomorphism may make organizations more similar without necessarily making them more efficient” (p147), implying that structures signal rationality, irrespective of their effects on outcomes. However, some researchers have found that isomorphism can have a positive effect on organizational legitimacy being granted to an organization’s strategy (Deephouse, 1996; Ruef & Scott, 1998; Westphal et al, 1997).

Institutionalist’s argue that the central purpose of conformity to commonly used strategies, structures, and practices is to appear rational to the institutional environment and therefore to be considered as acceptable and gain social credibility (Fligstein, 1991; Tolbert & Zucker, 1983). In a similar vein, resource-dependency theorists argue that organizational legitimacy is necessary for organizational survival (Pfeffer & Salancik, 2003), as without it, the organization would risk access to resources and place its existence in jeopardy (Dowling & Pfeffer, 1975).

Conflict, consensus, and organization theories have all helped shape the many definitions of legitimacy found across the organizational literature. Common themes associated within

these definitions typically emphasize issues of influence, power and authority (Gramsci, Habermas, 1975; 1947; Parsons, 1958; Pfeffer & Dowling, 1975; Pfeffer & Salancik, 1978; Weber, 1918, 1978), cultural conformity (DiMaggio & Powell, 1991; Meyer & Scott, 1983b), perceptions of credibility and validity (Elsbach, 1994; Elsbach & Sutton, 1992; Human & Provan, 2000; Meyer & Rowan, 1991; Scott et al, 2000; Suchman, 1995), moral congruence and social identity (Brown, 1997; Clegg et al, 2007; Festinger, 1957; Kelman, 1958, 2001; Vaaro et al, 2006; Weick, 1995), and justice (Brockner, 2002; Hegtvedt & Johnson, 2000; Lind & Tyler, 1988; Tyler, 2001).

For example, Meyer & Scott (1983b) depict legitimacy as stemming from congruence between the organization and its cultural environment as it "refers to the extent to which the array of established cultural accounts provide explanations for an organization's existence" (p201). Suchman (1995) emphasizes the evaluative and cognitive dimensions by defining legitimacy as, "A generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed systems of norms, values, beliefs, and definitions" (p574).

Kelman (2001) presents the core characteristic of legitimacy as "the moral basis of social interaction…which arises in an interaction or relationship between two individuals, or between one or more individuals and a group, organization, or larger social system, in which one party makes a certain claim, which the other may accept or reject. Acceptance or rejection depends on whether that claim is seen as just or rightful" (p55).

In terms of the legitimacy-building process, the justice-orientated perspective argues, "when people are making evaluations of the legitimacy of social authorities, they focus almost exclusively upon their assessments of the fairness of the procedures those authorities use to make decisions. Judgements about the favourability or fairness of the outcomes themselves have little impact upon people's evaluations of the legitimacy of those authorities, or of the institutions that they represent" (Tyler, 2001: p416). Zelditch (2001a) captures the general overarching theme in most of the above definitions by simply concluding, "Something is legitimate if it is in accord with the norms, values, beliefs, practices, and procedures accepted by a group" (p33).

In developing a working definition of 'strategy legitimacy' at the end of this chapter, this thesis draws on Suchman's (1995) evaluative and cognitive dimensions of legitimacy, as well as Kelman's (2001) moral-orientated conceptualisation. Like many other legitimacy

researchers (see p61), Suchman and Kelman view legitimacy as a concept which is intrinsically subjective and socially constructed[6] (Ashforth & Gibbs, 1990; Berger & Luckmann, 1967; Deephouse & Carter, 2005; Kelman, 2001; Meyer & Rowan, 1977; Pfeffer & Salancik, 2003; Suchman, 1995; Zelditch, 2001).

3.1.2 Frameworks of legitimacy

How the concept of legitimacy is understood in organizations has been supported by the development of various frameworks or models of legitimacy (see Table 3.1.2). Many of these legitimacy frameworks predominantly draw upon institutional theory as their theoretical foundation (DiMaggio & Powell, 1983, 1991; Meyer & Rowan, 1977; Scott, 1995). Different legitimacy-typologies and frameworks overlap to some extent, and all of them generally compliment those definitions of legitimacy which are based on issues of power, moral congruence, cognitive validity, and justice (Dornbusch & Scott, 1975; Kelman, 2001; Suchman, 1995; Tyler, 2001; Weber, 1918/1968).

These frameworks have been applied across a number of organizational contexts such as analyzing the role of entrepreneurs in emerging industries (Aldrich & Fiol, 1994), transition economies and multinational environments (Ahlstrom & Bruton, 2001; Kostova & Zaheer, 1999), mergers and alliances (Dacin et al, 2007; Kumar & Anderson, 2000; Kumar & Das, 2007; Terry & O'Brien, 2001; Vaara & Tienari, 2002), the creation of new industries and business networks (Aldrich & Fiol, 1994; Clegg et al, 2007; Human & Provan, 2000, Zimmerman & Zeitz, 2002), organizational crisis (Arthaud-Day et al, 2006; Brown, 2005; Dutton & Dukerich, 1992; Elsbach, 1994), organizational survival (Ruef & Scott, 1998), new growth ventures (Zimmerman & Zeitz, 2002), enhancing organizational reputation (Deephouse & Carter, 2005), restructuring (Vaara et al, 2006), and the development of new organizational forms (Chakravarthy & Garguilo, 1998; Suddaby & Greenwood, 2005).

Those frameworks offered by DiMaggio & Powell (1983), Meyer & Rowan (1977), and Scott (1995), are macro-level orientated and place greater emphasis on legitimacy within institutional fields, populations, and at an organizational level. Consequently, these frameworks afford less scope to analysing the internal micro level aspects of legitimacy from

[6] Berger & Luckmann (1967) describe the process of legitimation as a "second-order objectivation of meaning" (p110), and as institutionalised activities develop repeated patterns of behaviour, they evoke shared meanings or 'typifications' among participants which connect to wider cultural frames, norms, or rules (Scott, 2001: p92). Actors ascribe 'cognitive validity' to these meanings, and in doing so, project their own meanings into reality within the world which they have externally constructed (Berger & Luckmann, 1967: p122).

Table 3.1.2 Legitimacy in the organizational literature

Authors	Perspectives on legitimacy	Illustrative observations	Remarks
Ahlstrom & Bruton (2001)	Categorises three types of legitimacy; resource, moral, and cultural which are important to organizations seeking legitimacy in international business environments	Incorporates resource-orientated view of legitimacy, sociological views that holds that organizational structures and personnel are used to demonstrate an organization's acceptability, and congruence between an organization and its cultural environment	Firms have some autonomy in how they wish to promote their legitimacy by conforming and manipulating environments, and by selecting environments where they may already have support
Aldrich & Fiol (1994)	Identifies two types of legitimacy: (a) cognitive legitimacy, and (b) sociopolitical legitimacy	"New organizations are always vulnerable to the liabilities of newness but never more so than when entrepreneurs have few precedents for their actions" (p633)	Cognitive legitimacy is essential to gain inter partner legitimacy whereas socio-political legitimacy is a pre requisite for external legitimacy
Ashforth & Gibbs (1990)	The purpose of legitimation is to (a) extend legitimacy, (b) maintain legitimacy, and (c) defend legitimacy. Two approaches are through substantive and symbolic management practices	"Organizational legitimacy is a valued but problematic resource" and, "The very need for legitimacy may trigger events which prevent the realization of that need" (p191)	The greater the need for legitimacy, the more difficult it might be to attain it.
DiMaggio & Powell (1983)	Emphasize is placed upon institutional isomorphism, by focusing attention on coercive, normative, and mimetic mechanisms which are used by organization's in seeking legitimacy	"Isomorphism may make organizations more similar without necessarily making them more efficient" (p147), implying that structures signal rationality, irrespective of their effects on outcomes.	Isomorphism leads to legitimacy
Elsbach (1994)	The management of organizational legitimacy may be critically influenced by impression management tactics that reinforce the institutionalization process	"Impression management and institutional theories may therefore describe distinct aspects of symbolic management (i.e. the forms and contents) that can fulfil complimentary goals when combined in organizational accounts (p60)	A successful legitimation strategy needs to be able to successfully blend content with style.

Table 3.1.2 Legitimacy in the organizational literature (cont.)

Authors	Perspectives on legitimacy	Illustrative observations	Remarks
Human & Provan (2000)	Network legitimacy is composed of three distinct dimensions: (a) network as form, (b) network as entity, and (c) network as interaction	"Although both internal and external network support are eventually needed, building the three dimensions of legitimacy from inside out may be a more effective strategy in the long run than trying to first gain outside support" (p361).	Establishing legitimacy from inside-out may have greater sustaining power in the long run than an outside-in strategy.
Kostova & Zaheer (1999)	There are multiple levels of organizational legitimacy	"The tension between internal and external legitimacy, while more apparent to the multinational enterprise (MNE) case, also applies to some extent to all complex organizations" (p77).	The requirements for maintaining and enhancing cooperation with one's partner may conflict with the requirements of attaining inter partner legitimacy.
Kumar & Das (2007)	Suchman's (1995) three perspectives of pragmatic, moral, and cognitive legitimacy and are adopted and applied to inter-partner legitimacy in the alliance development process	"Inter-partner legitimacy is the mutual acknowledgement by alliance partners that their actions are proper in the development processes of the alliance." (p1). "Different types of legitimacy play different roles at different stages of alliance evolution" (p2)	"The focus of legitimacy work has been on external legitimacy as opposed to internal legitimacy. Internal legitimacy refers to the acceptance of an organization by its internal constituents" (p3).
Meyer & Rowan (1977)	Organizations use strategies, structures and practices that meets with social approval (i.e. confers legitimacy upon the organization) (cf. Johnson & Greenwood, 2007: p15)	Organizations do not necessarily conform to set beliefs because they "constitute reality" or are taken-for-granted, but because they are rewarded for doing so through increased legitimacy, resources, and survival capabilities (cf. Scott, 1987: p498).	Managers do not 'choose' whether to conform [with strategies, structures and practices], but simply 'do' because alternatives are not recognized (cf. Johnson & Greenwood, 2007: p16)

Table 3.1.2 Legitimacy in the organizational literature (cont.)

Authors	Perspectives on legitimacy	Illustrative observations	Remarks
Neilson & Rao (1987)	Legitimation is a process of making meaning	"There is little doubt that dominant coalitions have a vested interest in legitimacy, and more often than not, they exert considerable control over communication, possess access to relevant data, enact desirable facades, and coordinate performances, for the benefit of others" (p531).	The process of legitimacy involves three types of political behaviour: (a) politics of awareness; (b) politics of trust, and (c) politics of propriety.
Ruef & Scott (1998)	Legitimacy measures need to take into account the unique characteristics of an organization. In hospitals, the relevant forms of legitimacy are managerial and technical	"The salience of managerial and technical form of normative legitimacy can fluctuate across different institutional regimes" (p898).	All forms of legitimacy may not be relevant under all circumstances.
Scott (1995)	There are different types of legitimacy, each associated with a particular pillar of the institutional environment.	"However, from an institutional perspective, legitimacy is not a commodity to be possessed or exchanged but a condition reflecting the cultural alignment, normative support, or consonance with relevant rules or laws" (p45).	The three conceptions of legitimacy may lead to rather different conclusions about the legitimacy of the organization.
Suchman (1995)	There are different types of legitimacy: (a) pragmatic, (b) moral, and (c) cognitive.	"Legitimacy is a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate, within some socially constructed system of norms, values, beliefs, and definition" (p574).	While it is not possible for organizations to satisfy all audiences, management, through actions can enhance the appropriateness of organizational activities. Cognitive legitimacy is the most difficult to attain, but by the same token, may also be the most durable.
Zimmerman & Zeitz (2002)	Legitimacy is important for new ventures.	"An organization must achieve a base level of legitimacy that is dichotomous – it either does or does not meet the [legitimacy] threshold" (p428)	Beyond a critical threshold, legitimacy is a matter of degree.

those constituents inside the organization. There are limitations to such institutional frameworks from a practice perspective in that they fail to capture the potential for issues of human agency and pragmatic self-interest (Johnson et al, 2003; Whittington, 2006)[7].

Scott's (2001) legitimacy framework potentially offers some utility for this thesis. Scott (2001) elicits three related but distinguishable 'pillars' of legitimacy: regulative, normative, and cultural-cognitive. Scott's regulatory pillar emphasizes conformity to rules: legitimate organizations are those established by and operating in accordance with relevant legal or quasi-legal requirements.

The normative pillar stresses a deeper, moral base for assessing legitimacy. Normative controls are much more likely to be internalized than are regulative controls, and the incentives for conformity are likely to include intrinsic as well as extrinsic rewards. The cultural cognitive pillar stresses the legitimacy that comes from adopting a common frame of reference or definition of the situation. To adopt an orthodox structure or identity to relate to a specific situation is to seek the legitimacy that comes from cognitive consistency.

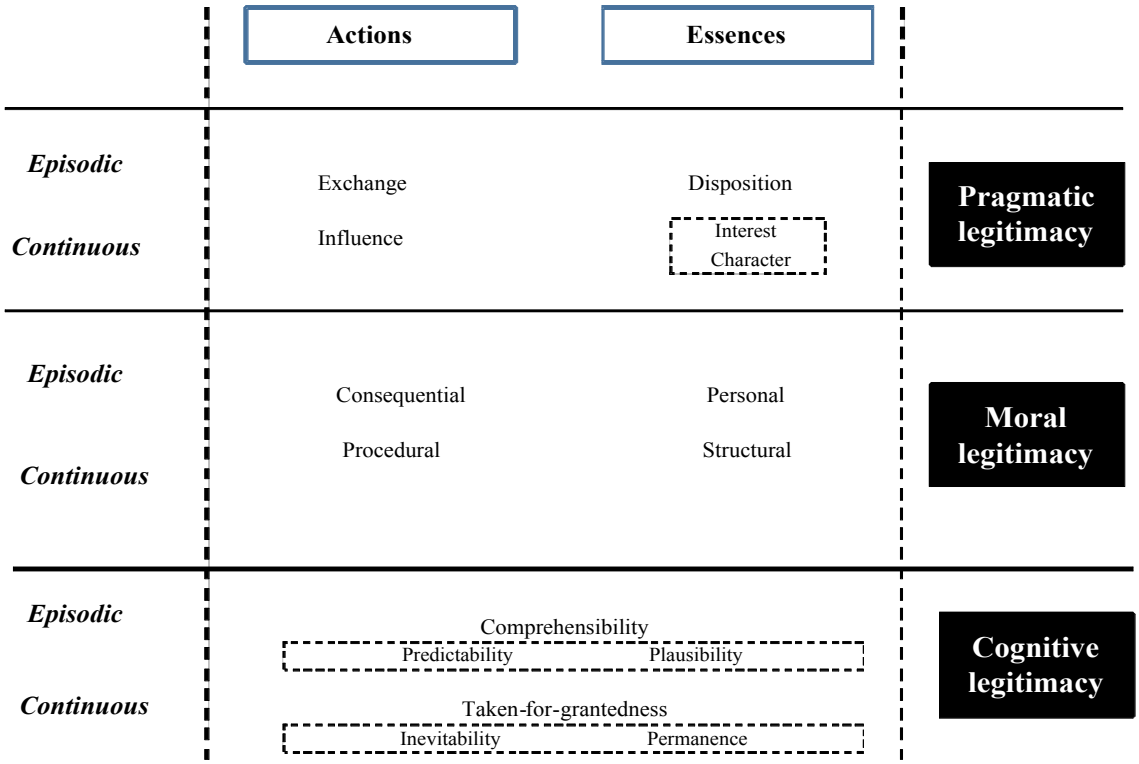
The cultural-cognitive mode is the "deepest" level because it rests on preconscious, taken-for-granted understandings. The bases of legitimacy associated with the three elements of Scott's pillars are different and may, sometimes, be in conflict (p61). However, it is the research possibilities offered by Suchman's (1995) legitimacy framework that outweigh those of Scott's (2001) framework. Suchman's framework includes three types of legitimacy which are multi variant. These legitimacy-types are now described in more detail, and summarized in Illustration 3.1.2.

Since its publication in 1995, Suchman's (1995) paper on strategic and institutional approaches to managing legitimacy has been widely cited by the vast majority of researchers concerned with strategy and legitimacy (Ahlstrom & Bruton, 2001; Brown, 1998, 2000; Clegg et al, 2007; Currie & Brown, 2003; Deephouse & Carter, 2005; Golant & Sillince, 2007; Human & Provan, 2000; Jarzabkowski, 2005; Kostova & Zaheer, 1999; Kumar & Das, 2007; Li et al, 2007; Ruef & Scott, 1998; Suddaby & Greenwood, 2005; Tyler, 2006; Vaara et al, 2006; Zimmerman & Zeitz, 2002). Suchman's (1995) paper initially synthesizes the [pre-1995] literature on organizational legitimacy, and the outcome of this process is the

[7] It is acknowledged that agency has received some attention within neo-institutional theory frameworks (Barley, & Tolbert, 1997).

identification and categorization of three primary forms of legitimacy: pragmatic, moral, and cognitive.

Illustration 3.1.2 Suchman's legitimacy typologies and their variants (1995)



Pragmatic legitimacy variants include exchange, influence, and dispositional legitimacy *Exchange legitimacy* rests on the self-interested calculations of an organization's most immediate audiences, and where support for an organizational policy based on that policy's expected value to a particular set of constituents. *Influence legitimacy* entails support of the organizations not necessarily because they believe that it provides specific favourable exchanges, but rather because they consider it as being responsive to their larger interests.

Suchman (1995) points out that influence legitimacy arises when the organization involves constituents into its policy-making structures. An indicator of an organizations commitment to employee well-being is the organizations willingness to relinquish some measure of authority to their employees by co-opting them into the decision or design process (Selznick, 1949). *Dispositional legitimacy* regards organizations as 'individuals' which share actors

values to the extent that they are viewed as "trustworthy" and "decent" and "wise". (cf. Suchman, 1995: p578).

Moral legitimacy variants include consequential, procedural, structural, and personal legitimacy. Moral legitimacy rests not on judgements about whether a given activity benefits the evaluator, but rather on judgements about whether the activity is "the right thing to do" (p579). It takes four forms: evaluations of outputs and consequences (consequential legitimacy), evaluations of techniques and procedures (procedural legitimacy), evaluations of categories and structures (structural legitimacy), and evaluations of leaders and representatives (personal legitimacy)[8].

Consequential legitimacy is conferred upon the basis that organizations should be judged by what they accomplish (Meyer & Rowan, 1991) or "socially valued consequences" (Suchman, 1995: p580). *Procedural legitimacy* arises when organizations embrace socially accepted techniques and procedures. Such legitimacy becomes more significant in the absence of clear outcome measures (Scott, 1992) when "sound practices" (Suchman, 1995: p580) may serve to demonstrate that the organizations are making a good-faith effort to achieve valued, albeit invisible, ends.

Structural legitimacy is conferred when audiences see the organization as valuable and worthy of support because of its structural characteristics and their capacity to perform specific types of work, which can be influenced by the organization displaying structural traits which are common to the institutional fields in which it is situated (cf. Meyer, 1977). *Personal legitimacy* rests on the charisma of individual organizational leaders and the personal influence that they exercise upon others (cf. Suchman, 1995: 579-581)

Cognitive legitimacy consists of comprehensibility and taken-for-grantedness. Cognitive legitimacy is determined by whether an organization seeks passive versus active support. Two variants are significant: legitimacy based on comprehensibility, and legitimacy based on taken-for-grantedness. The latter is considered to be conceptually distinct from the former (cf. Jepperson, 1991). *Comprehensibility* is required when the social world is viewed as a chaotic

[8] Suchman (1995) adds that these four types of moral legitimacy which he identifies are roughly parallel to Weber's (1978) discussion of legitimation authority. Consequential legitimacy and procedural legitimacy both reflect legal-rational authority, although the forms are instrumentally rational (based on the pursuit of particular goals), where the latter is value-rational (based on the fulfilment of rules of proper behaviour) (Weber, 1978). Structural legitimacy reflects traditional authority, based on the longstanding designation of certain types of actors as worthy of exercising certain types of power. Finally, the personal legitimacy of leaders and representatives corresponds to the Weberian ideal-type of charismatic authority. (cf. Suchman, 1995: p579).

cognitive environment in which participants struggle to arrange their experiences into coherent understandable accounts (cf. Mills, 1940; Scott & Lyman, 1968).

Cognitive legitimacy then stems from the availability of cultural models that furnish plausible explanations for the organization and its activities (cf. Scott, 1991). In the presence of such models, organizational activity will prove predictable, meaningful, and inviting; in their absences, activity will collapse – not necessarily because of overt hostility (although this is possible given the threatening nature of the inexplicable), but more often because of repeated miscues, oversights, and distractions. Comprehensibility, therefore, must connect with both larger belief systems and with the experienced reality of the audience's daily life (cf. DiMaggio & Powell, 1991).

In contrast, *taken-for-grantedness*, which is firmly rooted within the institutional perspective (Powell, 1991; Zucker, 1983), does not depict the social world as one of cognitive chaos. According to this view, institutions not only render disorder manageable, they actually transform it into a set of inter-subjective "givens" that submerge the possibility of dissent. Zucker (1983: p25) identified legitimacy with cognitive "exteriority and objectivity", therefore signifying the removal of an aspect of social structure from the presumed control of the very actors who initially created it, so that 'for things to be otherwise is literally unthinkable'". This kind of taken-for-grantedness represents the most subtle and the most powerful source of legitimacy. If alternatives become unthinkable, challenges become impossible, and the legitimated entity becomes unassailable by construction. This type of legitimation is generally considered to lie beyond the reach of managers (cf. Suchman, 1995: p582-583).

Suchman (1995) framework raises four important points for this thesis:

- the multidimensional nature of legitimacy
- the inter-relationships legitimacy variants have to each other
- the manageability or fostering of pragmatic, moral, and cognitive legitimacy
- and under what type of conditions each form of legitimacy emerges in the strategy process

First, Suchman (1995) presents legitimacy as a multidimensional construct. He raises questions about what *form* of legitimacy strategy researchers are discussing or applying in

their research, because there are clear distinctions between pragmatic legitimacy, moral legitimacy, and cognitive legitimacy. However, this is not commonly highlighted in the strategy literature, and the form of legitimacy which strategy researchers refer to often remains ambiguous in strategy studies (Varra et al, 2006).

Second, Suchman (1995) notes that pragmatic legitimacy rests on audience self-interest, whereas moral and cognitive legitimacy do not. Pragmatic assessments are largely based on personal calculations, and organizations can often purchase pragmatic legitimacy by offering instrumental rewards. In contrast, moral and cognitive legitimation implicates larger cultural rules, even when rewards are offered to audiences. Both pragmatic and moral legitimacy rest on discursive evaluation, whereas cognitive legitimacy does not. Audiences arrive at cost-benefit appraisals and ethical judgements largely through explicit public discussion, and organizations can often win pragmatic and moral legitimacy by participating in such discussions.

Suchman (1995) summarizes, "together, these observations suggest that as one moves from the pragmatic to the moral to the cognitive, legitimacy becomes more elusive to obtain and more difficult to manipulate, but it also becomes more subtle, profound, and more self-sustaining, once established" (p585). This point raises an important question from a strategy-as-practice perspective as to the extent that managers can manipulate the more 'elusive' aspects of legitimacy in a practical sense, as there is no "actionable guidance" (Johnson et al, 2003: p15) currently available to them on this area.

Third, Suchman (1995) states, "although different types of legitimacy often reinforce one another, they occasionally come into conflict as well" (p585). Furthermore, he adds, "friction among pragmatic, moral, and cognitive considerations seem most likely to arise when larger social institutions either are poorly articulated with one another or are undergoing historical transitions" (p585). This suggests that different forms of legitimacy are more likely to come into conflict with each other during major strategic change. When different types of legitimacy either reinforce or come into conflict with each other, this could have major implications for the nature of the relationship between legitimacy and commitment i.e. if it remains reciprocal or not during strategic change.

Fourth, Suchman (1995) asked whether particular environmental conditions are distinctively congenial to particular types of legitimacy or distinctively conducive to particular legitimation strategies (p604). The conditions, or strategic context, which umbrella strategies

create are of particular interest to this thesis, especially in relation to pragmatic legitimacy – and more specifically *influence legitimacy* - and the practice of 'co-opting' constituents into the strategy process (Mintzberg & Waters, 1985). To reiterate Suchman (1995: p578), "an indicator of an organizations commitment to employee well-being is the organizations willingness to relinquish some measure of authority to their employees by co-opting them into the decision or design process" (cf. Selznick, 1949).

However, Suchman also points out that some theorists (Meyer & Rowan, 1991) have cited this as a form of managerial manipulation as it is easier to allocate or defer consensus to employees rather than provide immediate results. Therefore, participative approaches may be viewed sceptically by actors, which counter-act the aims of involving them in the first place to gain their commitment.

Another 'conditions' issue relates to judgements of moral legitimacy and whether an activity is "the right thing to do" (p579). These judgments usually "reflect beliefs about whether the activity effectively promotes societal welfare, as defined by the audience's socially constructed value system" (p579). However, Suchman (1995) acknowledges, "this altruistic grounding does not necessarily render moral legitimacy entirely interest-free" (p579). This suggests that even when actors judge whether an activity (e.g. strategic activity) is regarded as doing 'the right thing', they also hold the capacity and volition to consider whether to fully engage in the process. Subsequently, the potential for agency becomes a possibility.

In summary, Suchman's (1995) framework offers greater scope in comparison to Scott's (2001) from which to examine the relationship between legitimacy and commitment at a micro-level of analysis (Johnson et al, 2003). It also presents a broad, detailed conceptual framework from which to address the issue of human agency in a strategic context, for which the field of strategy has drawn criticism for not paying enough attention to (Jarzabkowski et al, 2007). It presents an opportunity to bring the human actor back to centre-stage within strategy research by analysing the legitimacy criteria and reasoning which middle manager actors deploy when strategizing under umbrella conditions (Mintzberg & Waters, 1985; Reger, 2003; Whittington, 2006).

The detailed forms of legitimacy which Suchman (1995) introduces may also help address some of the issues around conceptual ambiguity which Vaara et al (2006) have highlighted. Importantly, Suchman's typologies suggest actors' evaluations of the legitimacy of

organizations activities may comprise of a wide number of factors that require further empirical examination.

Finally, the relationship between pragmatic and moral legitimacy is of particular interest. As Suchman's (1995) concept of moral legitimacy suggests the potential for human agency, a prospective middle manager dilemma emerges: 'Is this the right thing to do?' from a moral legitimacy perspective and 'Will I actually go along with it?' from a pragmatic stance. This dilemma raises the potential for discrepancy to emerge between the explicitly-stated espoused change targets prescribed in the deliberate outlined aspects of umbrella strategy, and the emergent discretionary practices which middle manager actors employ as they 'work on the finer details' of strategy goals.

For example, even though their roles may be changing as a result of a new strategy, middle managers are also expected to be agents of change as well as being recipients of changes taking place. This can create role conflict (Balogun, 2003; Currie & Proctor, 2005; Floyd & Lane, 2000). As Turnbull (2001) has highlighted, the potential for middle managers to find themselves in tension with the ideological messages cascading from the top of their organization requires them to promote corporate values and policies which may conflict with their own personal values, and leave middle managers advocating policies which have personal consequences for them both as a group and individually.

In this type of situation, Giangreco & Peccei (2005) illustrated how overt resistance is not a feasible option for middle managers, and the principal way they expressed their indifference with programmes of change taking place in their organization was by failing to engage more actively in various forms of pro-change behaviour (e.g. promoting the change with enthusiasm, convincing others of its appropriateness and vigorously supporting change in public discussions) rather than a propensity to engage in more open and active forms of dissent (e.g. being critical of changes in public, supporting the actions of colleagues who are also against the change, making complaints to superiors).

Institutional theorists have suggested that actors act more passively in these circumstances, believing that broader institutional rules constrain - or guide - them from doing nothing else but complying with actions that they do not agree with, yet they still carry them out (Greenwood & Hinings, 1996). However, little is understood about the way in which middle

managers respond to developing and implementing strategy goals in umbrella contexts which they do not approve of.

This issue merits enquiry because it may offer some insight into how middle managers, in their role as 'strategists' (Jarzabkowski et al, 2007), reconcile themselves to developing and promoting strategy goals 'en route' that potentially conflict with their own personal or professional values. Although Giangreco & Peccei (2005) have suggested that middle managers tend to express their indifference to planned programmes of change which they are uncomfortable with in less overt ways, questions remain as to whether this is the case in umbrella contexts where middle managers have been awarded the strategist role (Giddens, 1984; Jarzabkowski, 2005).

3.1.3 Internal and external sources of legitimacy

Legitimacy from the environment has largely been the focus of both institutional (DiMaggio & Powell, 1983; Meyer & Rowan, 1977) and resource-dependency theorists (Pfeffer & Salancik, 1978), who have traditionally emphasized the role of the external environment in providing validation to organizations by conferring legitimacy upon them in return for resources and social acceptance (Parsons, 1960; Pfeffer & Dowling, 1975). This research has typically focused on 'organizational legitimacy'. Pfeffer & Salancik's (2003) definition of organizational legitimacy reflects this external orientation as "it places emphasis on how organizations are components of a larger social system and depend on that systems' support for their continued existence, where organizational goals and activities must be legitimate or of worth to that larger social system" (p193).

Organizational legitimacy is widely acknowledged as important to organizations for several reasons, particularly for its role in shaping the success and failure of organizational action, organizational survival, and social credibility (Human & Provan, 2000; Kelman, 2001; Meyer & Rowan, 1977; Scott, 2001; Suchman, 1995; Suddaby & Greenwood, 2005; Zelditch, 2001; Zucker, 1987). Scott et al (2000) have argued in putting forth the social dimension of legitimacy, "organizations require more than material resources and technical information if they are to survive and thrive in their social environment…they also need social acceptability and credibility" (p10).

Social approval is also considered to be important for organizational reputation (Deephouse & Carter, 2005), and where this is questioned, "organizations are more vulnerable to claims

that they are negligent, irrational or unnecessary" (Meyer & Rowan, 1991: p50) particularly when maintaining or repairing legitimacy in times of crisis (Brown, 2005; Elsbach, 1994) where they become subject to "legitimacy challenges" from their stakeholders (Deephouse & Carter (2005: p333).

Organizational legitimacy allows access to resources (Zimmerman & Zeitz, 2002) which would not be accessible otherwise. Where legitimacy is not granted to an organization, its ability to pursue its goals and accumulate resources can be substantially reduced and consequently create constraints for the ways in which it can operate (Dowling & Pfeffer, 1975). Although many researchers take the normative view that legitimacy is required for access to resources, Kostova & Zaheer (1999) offer a different view by arguing that it is possible for an organization not to be wholly legitimate and still be profitable and to even survive over the long-term if it has alternative sources of resources and organizational support (p77).

Maintaining organizational legitimacy is considered to play a significant role in supporting the continuing survival of the organization (Pfeffer & Salancik, 2003; Zimmerman & Zeitz, 2002) and exerts an influence on organizational viability independent of its performance, attributes, or connections (Scott, 2001). For example, Parsons (1956) argued that because organizations consume society's resources, they are always under scrutiny concerning the value that they reciprocate towards society and that this evaluation includes as assessment of the nature of their activities. Where organizations make their value known to constituencies, support is subsequently given by constituents based on the expected value the organization offers (Dowling & Pfeffer, 1975). Pfeffer & Salancik (2003: p194) add that "survival depends upon whether the organization develops goals and operations perceived as legitimate by the larger society" (p194).

As legitimate organizations are viewed as inherently more trustworthy (Suchman, 1995) organizations can leverage this trust to improve access to resources (Pfeffer & Salancik, 1978), however, the threat of loss of legitimacy can disrupt the flow of necessary resources into a firm (Arthaud-Day et al, 2006). Suchman (1995) noted the negative effects of firm failure associated with loss of legitimacy. External constituents are likely to distance themselves from those organizations to avoid the risk of "negative contagion" (p597) by taking with them the financial, social, and intellectual capital that the damaged firm needs to

recover and survive. This argument supports the view that legitimacy is itself a resource (Ashford & Gibbs, 1990).

Organizational legitimacy is "problematic" for organizations regardless of their size or their age (Ashford & Gibbs, 1990: p177; Baum & Oliver, 1991; Pfeffer & Salancik, 2003). Maintaining legitimacy continues to remain important to older organizations (Ruef & Scott, 1998) and professional groups in established industries (Suddaby & Greenwood, 2005) who are intent on attracting as well as retaining constituents (Ashford & Gibbs, 1990; Dutton & Dukerich, 1990).

Ahlstrom & Bruton (2001) stress the importance of organizational legitimacy to firms entering new foreign markets since their right to exist and conduct business may be significantly questioned, unlike in their home markets. They argue that legitimacy-building is a crucial strategic behaviour for firms in order to establish and maintain their right to exist, and to enable them to operate freely. Lacking legitimacy may act as a barrier to entry into new global markets for established multinational enterprises (Kostova & Zaheer, 1999), and is recognized as critical for entrepreneurs embarking upon new international ventures (McGaughey, 2007) where they must meet a legitimacy "threshold" (Zimmerman & Zeitz, 2002: p414). For small firms operating within less mature and developing multi-lateral networks, the failure to build legitimacy or "credibility" can lead to network collapse (Human & Provan, 2000: p328).

However, there is growing acknowledgement and support for the view that legitimacy is pertinent to internal constituents also (Ruef & Scott, 1998), and that it is not just an external macro-level phenomena which many institutional and resource-dependence theorists have claimed it to be. Elsbach & Sutton (1992) state, "Legitimacy is conferred when stakeholders – that is, internal and external audiences affected by organizational outcomes – endorse and support an organization's goals and activities" (p700). Kostova & Zaheer (1999) also argue that complex organizations face two institutional environments: the external environment and the internal environment. As such, internal legitimacy results from the acceptance, approval and adoption from within "subunits" of the organization structures, policies and practices institutionalised within the wider organization as a whole (p72). Furthermore, they argue that complex organizations such as multinational enterprises are compromised of multiple levels of organizational legitimacy, and tensions can emerge between internal and external organizational bases of legitimacy.

Human & Provan (2000) distinguished between internal and external legitimacy with regards to multi firm business networks. They argued that firms need not seek legitimacy from the external environment as a matter of course, but concluded, "both internal and external network support are eventually needed, [but] building the dimensions of legitimacy from 'inside out' may be a more effective strategy in the long run than trying to first gain outside support" (p361). They even argued that establishing legitimacy from the 'inside out' may have greater sustaining power in the long term than an 'outside in' strategy.

This thesis argues that *organizational legitimacy* and *strategy legitimacy* can be considered as conceptually-related but are distinct foci of analysis when examined during strategic change. It is acknowledged that external legitimacy is certainly important for all organizations (DiMaggio & Powell, 1991; Meyer & Rowan, 1977; Pfeffer & Salancik, 1978) and this view is not being challenged or questioned in this thesis. However, internal legitimacy is particularly critical for organizations whose external [organizational] legitimacy is well-established (Ruef & Scott, 1998), because these organizations still require gaining support and acceptance from their internal constituents with respect to strategic change to ensure that the execution of espoused strategic action is accomplished successfully.

This leads to the question of who exactly confers internal legitimacy, particularly during strategic change. This question follows a long-standing debate within the legitimacy field, namely, the question as to 'whose assessments count' in determining the legitimacy of a set of arrangements (Scott, 2001: p60).

The emphasis upon leadership or top management legitimacy (Chakrvarthy & Garguilo, 1998; Dooley et al, 2000) has meant the neglect of attention towards the legitimacy of those who are more actively involved in implementing strategic changes, specifically middle managers (Floyd & Wooldridge, 2000; Mantere, 2007). As practice researchers have argued, we need to know more about what is going on in the strategy process outside of top management teams (Balogun et al, 2007; Rouleau, 2005). In the context of studying strategic change, this therefore requires attention to be given to the legitimacy appraisals of those actors responsible for implementation.

This is important because those at the top end of the organization hierarchy are rarely, if ever, involved in the practical frontline implementation of strategic change in the same way that middle managers are (Balogun, 2003; Rouleau, 2005). This thesis argues that *organizational legitimacy* and *strategy legitimacy* can be considered as conceptually-related but are distinct

foci of analysis when examined during strategic change. It is acknowledged that external legitimacy is certainly important for all organizations (DiMaggio & Powell, 1991; Meyer & Rowan, 1977; Pfeffer & Salancik, 1978) and this view is not being challenged or questioned in this thesis. However, internal legitimacy is particularly critical for organizations whose external [organizational] legitimacy is well-established (Ruef & Scott, 1998), because these organizations still require gaining support and acceptance from their internal constituents with respect to strategic change to ensure that the execution of espoused strategic action is accomplished successfully. (Jarzabkowski et al, 2007).

A high volume of empirical studies cover a wide range of legitimacy issues within the strategy literature. However, for research and analytical purposes, Kelman (2001) argues that legitimacy should be evaluated on two levels. The first concerns the legitimacy of *the claim* itself, or of the action, policy, demand, or request that reflects that claim. The second, concerns the legitimacy of *the claimant* – of the person, group, organization, or larger social system that makes the claim or provides the backing for it.

Kelman's second level reflects the traditional approach to studying legitimacy in strategy research, namely concerning the legitimacy of the organization or 'the claimant' (Ashford & Gibbs, 1990; Deephouse & Carter, 2005; Dutton & Dukerich, 1991; Elsbach, 1994; Kostova & Zaheer, 1999; Zimmerman & Zeitz, 2002). The 'claimant' has been the dominant analytical focus of institutional (Deephouse, 1996; DiMaggio & Powell, 1983; Meyer & Rowan, 1977; Oliver, 1991; Ruef & Scott, 1998; Scott, 2001; Zucker, 1987) and resource-dependency theorists (Pfeffer & Salancik, 1978).

In summary, the theoretical insights into organizational legitimacy which are drawn from strategy research have been critical to the wider understanding of legitimacy attainment, maintenance, and reproduction at a field and organizational level (Scott, 2001). However, the dominant analytical focus has remained firmly on 'the claimant', and strategy researchers have not given enough attention to the legitimacy of organizational 'claim(s)' in the form of action, policy, strategy etc. Therefore, in a departure from the traditional approach to examining legitimacy, this thesis is primarily concerned about the legitimacy of 'the claim' (the strategy), as opposed to 'the claimant' (the organization).

Kumar & Das (2007) point out that although the legitimacy literature has given much attention to the attainment, maintenance, and defence of legitimacy, "this work has been on external legitimacy as opposed to internal legitimacy…which refers to the acceptance of an

organization by its internal constituents" (p3). Kelman's (2001) points become especially pertinent in this respect, because they invite strategy researchers to offer clarity on *what* internal legitimacy issues they aim to analyse. It is how middle managers evaluate the legitimacy of 'the claim' or strategy goals, as opposed to 'the claimant' or organization which is the focal interest of this thesis. It is argued that internal legitimacy issues are more likely to preoccupy middle managers everyday experiences during strategic change (Samra-Fredericks, 2003), rather than wider issues relating to the organizations external credibility.

Furthermore, traditional approaches, which focus on 'the claimant', or organization, have typically adopted a broad macro-level view of organizations and their legitimacy by consistently emphasizing organizational survival, resource acquisition, and the salience of isomorphism. Such macro-level perspectives present limitations to strategy-as-practice researchers in developing a greater understanding of legitimacy in the strategic change process from a micro-level of analysis (Johnson et al, 2003). This study is interested in the way that internal constituents legitimize 'the claim' or strategy goals, and not those broader macro-level external issues which focus on issues of resource-dependency.

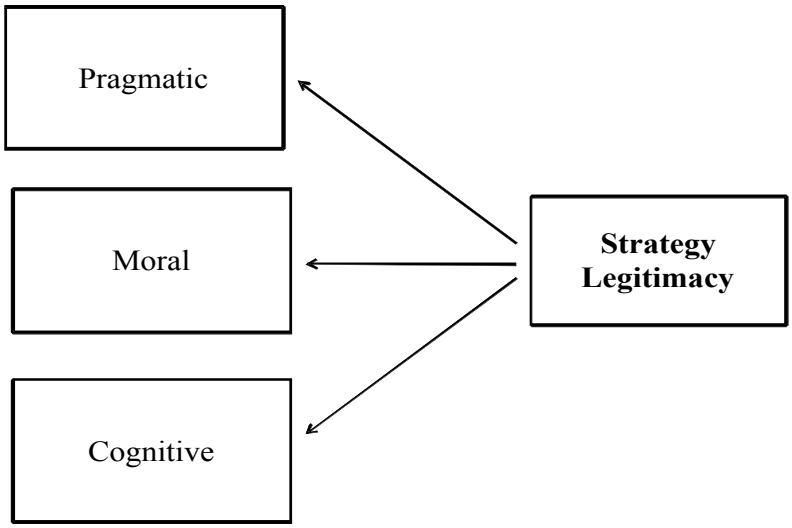
3.1.4 Defining strategy legitimacy

> "Strategy legitimacy is an internal micro-level evaluation on a pragmatic, moral, and cognitive level of actions which constitute 'the strategy' that are considered as desirable, proper, or appropriate by those strategists responsible for its development and implementation."

The theoretical basis of the *strategy legitimacy* definition draws firmly on Suchman's (1995) framework which comprises of pragmatic, moral, and cognitive legitimacy. Suchman's three primary forms of legitimacy offer greater specificity in defining what types of legitimacy are being referred to, and they emphasize the multidimensional nature of legitimacy. The definition addresses the problem of conceptual fragmentation and ambiguity which some researchers have highlighted as a problem within legitimacy studies (Tyler, 2001; Vaara et al, 2006).

The definition delineates *strategy legitimacy* from *organizational legitimacy*, and Suchman's (1995) legitimacy framework can be easily applied to examine legitimacy of 'the strategy' as opposed to the legitimacy of 'the organization' which emphasizes external sources of legitimacy. It offers the greatest scope from which to examine the relationship between legitimacy and commitment at a micro-level of analysis.

3.1.5 Illustrative dimensions of strategy legitimacy



3.2 COMMITMENT IN STRATEGY & MANAGEMENT DISCOURSE

There is wide recognition that the term commitment has been used with great flexibility (Guth & MacMillan, 1986; Hunt & Morgan, 1994; Jaros et al, 1993; Meyer & Allen, 1997; Meyer & Herscovitch, 2001). Mowday et al (1982) previously argued that this was due to "researchers from various disciplines ascribing their own meanings to the topic, thereby increasing the difficultly involved in understanding the construct" (p20). However, this viewpoint remains valid where references to commitment are used in discussions concerning strategic of management, organizational commitment, and change commitment.

With Meyer & Allen (1997) and Mowday et al's (1982) arguments in mind, attention requires to be given to the variance and broad usage of the term commitment within the strategy and management literature, in order to provide greater conceptual clarity on its use within this thesis. This section provides a discursive examination of the concept of commitment in order to illustrate how it is employed quite differently within three distinct discourses from the strategy and management literature, prior to defining what is meant by 'strategy commitment' in this thesis.

The three main discourses examined in this section include:

i. strategic management

ii. organizational commitment

iii. and change commitment

3.2.1 Commitment in strategic management discourse

Different perspectives on gaining commitment emerged in early strategic management research where debates on the degree of rigour associated with methodological analysis dominated (Guth, 1976). Ansoff (1965) rejected the necessity of gaining commitment to strategic decisions by arguing that consensus on goals was required, but which "the management responsible will arrive at" regardless (p112). Assuming that commitment to particular goals is established, the method for analysing strategy would allow no room for disagreement as to the proper strategic choices (Guth, 1976). However, this rational, economic and analysis-orientated perspective reinforced the view that "corporate strategy remained aloof from social systems relationships" (Guth, 1976: p390).

Developing the principles of strategic management purely on the grounds of the degree of analytical rigor prescribed to the planning process at the expense of little attention being awarded to social processes, and the need to gain managerial commitment for strategic decisions, was considered by some strategy researchers to be unproductive (Learned et al, 1969).

Wrapp (1967) challenged the concept of a single leader as the strategic decision maker, and argued that the real challenges of individual executives was the problem in gaining others' commitment to new strategic directions, and the difficulties of translating decisions into organizational action and co-operative relationships. Learned et al (1969) believed the potential for variation in top management teams around the acceptability of strategic commitments was due to strategy problems often being viewed from the perspective of managers' own professional and functional experience which were not consistent with those of the CEO.

Guth (1976) summarised this early strategy work on commitment by noting that the microeconomics, marketing, finance, and organizational theory of corporate strategy were "helpful to individual managers about how to commit the resources of their organizations strategically…and in providing guidance about strategic problems and alternatives facing their organizations, but of limited value in helping them think about how to transform their individual strategic thoughts and ideas into organizational commitments and action" (p390). Namely, that there was scope for taking cognisance of the social processes of influence and gaining the commitment of others in the organization to a potential course of action within the strategic management field.

Although some strategy researchers began to focus on strategy from a power and political perspective (Pfeffer, 1981; Pfeffer & Salancik, 1978; Quinn, 1981; Tushman, 1977), this apparent shift was only temporary[9]. Mintzberg et al (2009) recall "in the early 1980's, a wind from economics blew through the strategic management field" (p86), which reinforced the focus on analytical procedures for strategy formulation, and less so on social and political elements of strategy (e.g. Johnson, 1987; Pettgrew, 1985). The concept of commitment remained part of strategic management discourse, but its application produced new meaning,

[9] Quinn (1981) reflected this gradual shift in approaches to strategy making by observing, "A synthesis of power-behavioural and formal analytical approaches more closely approximates the processes major corporations use in changing their strategies" (p45).

particularly within the positioning school (Ghemawhat, 1991; Porter, 1980, 1985, 1998), and its relationship with planning (Lahr, 1983; Stone & Brush, 1996).

Ghemawhat's (1991) conceptualisation of commitment is economics-orientated, and concerns firms' moves with respect to capital investments, positioning, and sustained performance. In responding to strategic management trends during the 1980's where firms continually sought stable success factors, Ghemawhat (1991) presented commitment as a "dynamic constraint" (p14) which explained sustained firm performance differences and the irreversibility implicit to strategic management e.g. "the cost of changing one's mind" (p31). He defined commitment as "the tendency of organizations to persist with their respective strategies over time" (p13), and identified four possible causes for this: lock-in, lock-out, lags, and inertia.

Ghemawhat (1991) argued that commitment complicates choice because it requires predictions about the consequences of current actions when contemplating an optimal investment policy and concedes these cannot always be forecast with accuracy. He recommended managers use the concept of commitment to improve the quality of the choices they made by distinguishing between those choices from the level of commitment they each represented, and encouraged focusing on "commitment-intensive" (p51) strategic choices which demanded a cost-benefit analysis of significant sunk costs, opportunity costs etc.

In promoting strategic analysis, Ghemawhat (1991) also claimed to "facilitate the implementation of strategic options by forcing advance consideration of the actions that are required" (p51). However, despite this claim, no attention is given to those actors responsible for implementation, and this omission occurs at the expense of further elaboration upon financial margins, positioning, sustainability analysis, and value creation.

Porter (1998) refers to commitment within the context of the external, macro-level competitive firm environment, and promotes commitment as "the single most important concept in planning and executing offensive or defensive competitive moves" (p100). He describes commitment as a type of communication mechanism which signals corporate action through a series of unequivocal strategic moves that play a critical role in influencing the way firms perceive their own positions and how they are perceived by their competitors.

Porter identifies three major types of commitment in the competitive setting: (1) commitment that the firm is unequivocally sticking with a move it is making; (2) commitment that the firm

will retaliate and continue to retaliate if a competitor makes certain moves; and (3) commitment that the firm will take no action or forgo an action. Each type of commitment is designed to achieve deterrence of a different type such as deterring retaliation and deterring threatening moves from competitors. However commitment may also be designed to create trust by signalling moves to deescalate competitive battles.

Borrowing from the behavioural psychology literature (Keisler, 1971; Salancik, 1977a), Porter (1998) argues that commitment is related to the degree which it appears binding and irreversible, and where the timing of commitment moves are considered crucial in competitive markets. Assets and resources are pre-requisites in order to carry out commitments if the firm's moves are to achieve credibility, as well as communicating or publicly signalling the firm's intentions to carry out the commitment, however, public declarations of the firm's intentions to the industry makes it difficult for it to back down.

The concept of commitment has also been applied to game theory, and important in terms of how firms interact with each other (von Neumann & Morgenstern, 1944). Commitment is referred to by Regan (2007) as a "type of signalling" (p94). Commitment involves making one's signal irrevocable, and involves taking away your freedom to choose further actions in the event that something happens to trigger the commitment.

Overall, the strategic management conceptualization of commitment generally concerns corporate actions which are calculative in nature. These actions tend to be exclusive in terms of being conceived and executed only by those in top management positions. Hence, strategic management discourse is mainly concerned with commitment in relation to planning and decision making processes, for which it has received some criticism.

For example, Korsgaard et al (1995) found that the quality of strategic decisions themselves was not the only key factor to successful strategy making as Ansoff (1965) suggests. Korsgaard et al (1995) examined how decision-making procedures facilitated the positive attitudes believed to be necessary for cooperative relations in decision-making teams. The processes used to reach those decisions impacted on strategy team members' affective processes such as their commitment to the decision, their attachment to the team, and their trust in its leader upon completion of the strategy making process. Korsgaard et al (1995) argued that it is these responses that are critical antecedents of actors' cooperation in implementing strategic decisions and not simply the analytical rigor of the strategy analysis process.

Another important factor which Vila & Canales (2008) accuse strategic management discourse of neglecting is that strategic planning – when used to build managerial commitment - needs to place more emphasis on managers' "committing to a strategy" and less emphasis on fixed plans (p14). Managerial commitments to strict plans, investments, and operating budgets are "fragile" in rapidly-changing environments that subsequently make plans obsolete well before they were even deployed (p14). They also argue that gaining commitment to strategy results not from rigorous analysis, but from "a particular state of mind" of those managers who are also required to implement it (p16).

Staw (1981, 1997) called into question the merits of rational analysis, which has been much lauded within strategic management research, and its impact on the nature of managers' commitment (e.g. Andrews, 1971; Ansoff, 1965; Ghemawhat, 1992; Porter, 1980). Staw (1981) introduced the concept of 'escalation of commitment' where organizations tend to 'throw good money after bad' in attempts at managing a failing course of action. Organizations that choose not to abandon their original chosen course of action, instead commit ever-greater sums of money in the hope that matters will eventually improve. In practice, Staw (1981) found that managerial action eventually becomes irrational when the levels of resources committed to resolve problems exceeded those that a rational model of decision making would prescribe (cf. Hodgekinson & Sparrow, 2002: p19).

Mintzberg (1994) challenged the assumption within the planning literature which maintained "that the commitment of top management automatically fosters the acceptance of planning… and that planning itself automatically engenders commitment within the organization." (p160). Mintzberg claims commitment to be "the most popularly claimed pitfall of planning…where the assumption is that with the support and participation of the top management, all will be well" (p160). He questions whether the commitment of top managers is actually attained during the planning process where corporate planners and CEO's dominate planning and decision making with little genuine input from other managers. Where this is the case, he asks, "If planning is not committed to management...then how can management be committed to planning?" (p160).

Mintzberg (1994) also accused the planning school of treating strategy-making as a detached, analytical process "to be executed by systems rather than people" where "analytical detachment at the front end, in formulation, tends to impede personal commitment on the back end, in implementation" (p171). Although conceding that organizations need both

calculation and commitment as part of the strategy making process, Mintzberg (1994) argues that the planning school appears to have shifted its priorities too heavily in favour of calculation. The consequence of this shift has left organizations unable to maintain the personal commitment of managers and implementers as a consequence of this imbalance.

The main criticism of the concept of commitment within strategic management discourse from a strategy-as-practice perspective is the elusiveness of the human actor in the strategy process (Jarzabkowski et al, 2007). Guth & MacMillan (1986) noted that although some aspects of early strategic management research had been concerned with the problem of securing the organization's commitment (e.g. Tichy, 1983), not enough attention had been given to the problems of "self-interested interventions" (p313), and particularly those of middle managers. However, this top management analytical-orientation continues to persist when commitment is used in strategic management discourse, and the commitment of actors outside of top management teams, and the potential for these actors to pursue acts of managerial agency is rarely given consideration (Balogun et al, 2007; Mantere, 2007).

Instead, greater attention is given to the commitment of resources and what an organization's corporate action symbolizes to competitors (Ghemawhat, 1991; Porter, 1998). This occurs at the expense of focusing on the commitment of those actor's on the receiving end of planned decisions (Balogun & Hope-Hailey, 2004). Furthermore, the application of the concept of commitment in strategic management discourse tends to be heavily economics-orientated, biased in favour of strategy formulation, and situated at the macro-level as opposed to the micro-level – all characteristics of strategy research which strategy-as-practice researchers have expressed strong reservations about (Johnson et al, 2003; Jarzabkowski et al, 2007). Therefore, the strategic management conceptualization of commitment has little utility for this thesis.

3.2.2 Organizational commitment discourse

In the organizational behaviour literature, commitment is commonly categorized as 'work commitment' (Carmeli & Gefen, 2005). Five universal forms of work commitment are identified by Morrow (1993) which includes organizational commitment, occupational commitment, career commitment, job involvement, and the Protestant Work Ethic (Weber, 1934). This literature review section is solely concerned with the concept of organizational commitment, and not the other four forms of work commitment Morrow identifies (1993), as it is the organizational commitment literature which raises several epistemological and

conceptual issues for this thesis, in addition to offering different typologies from which commitment can be analyzed (Meyer & Allen, 1991; O'Reilly & Chatman, 1986).

First, the literature relating to organizational commitment is widely recognized as having received far greater attention in comparison to other forms of work commitment (Carmeli & Gefen, 2005; Morrow & McElroy, 1993). It has been argued that the main reasons that organizational commitment is such a popular research subject in the organizational behaviour field is because of its assumed impact on performance (Benkoff, 1997; Mowday, 1999; Randall, 1990), and how human resources can be developed as "a competitive weapon" (Morrow & McElroy, 2001: p177).

Numerous job performance studies indicate that employees with strong commitment to their organization work harder at their jobs and perform better than those with weak commitment (Bashaw & Grant, 1994; Benkhoff, 1997; Bycio et al, 1995; Decotiis & Summers, 1987; Konovsky & Cropanzano, 1991; Leong, et al, 1994; Luchak & Gellatly, 2007; Mayer & Schoorman, 1992; Meyer et al, 1989; Randall et al, 1990). Other research suggests that organizational commitment impacts on attendance and absenteeism (Gellatly, 1995; Meyer et al, 1993), retention and turnover (Humphrey et al, 2005; Jaros, et al, 1993; Mathieu & Zajac, 1990), and organizational citizenship behaviour[10] (Graham, 1991; Katz, 1964; Organ, 1988; Schaubroeck & Ganster, 1991; Smith et al, 1983).

For example, employees with strong continuance [organizational] commitment are more likely to stay with the organization than are those with weak commitment (Carmeli & Gefen 2005; Cohen, 2000; Meyer & Allen, 1996), while employees with strong commitment to the organization appear much more willing to engage in organizational citizenship behaviour than those with weak commitment. This research suggests that the choices people make, and how they act in their occupational life, is influenced by their level of commitment to the organization.

Organizational commitment studies tend to almost exclusively follow the positivist tradition, with Structural Equation Modelling (SEM), path-analysis and regression analysis techniques commonly used to quantitatively measure commitment variables. The organizational commitment field has characteristically been dominated by the application and testing of conceptual models ranging from two-dimensional (Angle & Perry, 1981; Mayer &

[10] Meyer & Allen (1997) describe organizational citizenship behaviour as work-related behaviour "that goes above and beyond that dictated by organizational policy and one's job description" (p34).

Schoorman, 1992), three-dimensional (Meyer & Allen, 1991), and four-dimensional models (Blau, 2003) using the above analytical methods.

Another common feature of this research is that it focuses heavily on the variety of antecedents and consequences of organizational commitment, typically examining variables such as organizational characteristics, person characteristics, and work experiences (Beck & Wilson, 2001; Meyer & Allen, 1997; Mowday, 1999; Steers, 1977). Self-report questionnaires and Likert-type scales are also standard, despite self-reporting bias and common variance methods being routinely cited as a limiting factor (Fedor et al, 2006; Herscovitch & Meyer, 2002; Meyer & Allen, 1997; Podsakoff, 1986).

Quantitative organizational commitment studies have significantly contributed to management and applied psychology research. The broad range of organizational-related commitment issues that it has focused upon is impressive. Yet, to date, there are few qualitative organizational commitment studies (Alatrista & Arrowsmith, 2004). Previous meta-analysis studies show that these are heavily outnumbered by those incorporating quantitative methods (Cohen, 1992; Mathui & Zajac, 1990; Organ & Ryan, 1995; Meyer et al, 2002).

It is argued that there are limitations to understanding the *basis* of actors' commitment solely via quantitative methods when commitment is framed as a set of objective, measurable variables (Bailey et al, 2009). Such studies which seek simple correlations fail to include the '*how*' or '*why*' questions around commitment (Morrow & McElroy, 2001; Mowday, 1999).

Furthermore, too few organizational commitment studies use longitudinal approaches. Some commitment researchers have argued that commitment-related studies must attempt to capture how commitment develops and changes over time (Beck & Wilson, 2001; Mowday, 1999). Such methodological concerns echo those of strategy-as-practice researchers who argue that in-depth, longitudinal qualitative data enables researchers to explore and examine the 'intimate detail' of micro-level activity in organizations (Balogun et al, 2007), which quantitative data and methods that capture data in one-off 'stable' periods fails to do.

There is a clear research opportunity for studying commitment using qualitative methods, especially by using actor's own narratives (Barry & Elmes, 1997), and to better understand how commitment develops over time using longitudinal approaches, as these methodological issues are particularly critical when examining the development of actors' commitment

towards the espoused strategy of their organization (Balogun & Johnson, 1998; Langley, 1999; Pettigrew et al, 1992).

Second, the high volume of organizational commitment research that has been produced over several decades contains a wide array of constructs (Matheui & Zajac, 1990; Meyer & Allen, 1997)[11]. There are many conceptual definitions of organizational commitment (Herscovitch & Meyer, 2001; Hunt & Morgan, 1994; Mowday, 1983), and the field has been accused of "conceptual fragmentation" due to the proliferation of terms used by commitment researchers (Jaros et al, 1993: p582).

Meyer & Allen (1997) highlighted the potential confusion caused by different labels being used to describe very similar constructs (e.g. the labels of 'calculative commitment' and 'continuance commitment' refer to the same construct), and where the same labels are used to describe different constructs (e.g. normative commitment as described by Caldwell et al.1990, differs from normative commitment as described by Allen & Meyer, 1990a).

This issue of 'conceptual fragmentation' or "semantic duplication" (Brooks & Wallace, 2006: p224) has led to much discussion within the field on 'the meaning of commitment', how it ought to be defined, and if it should be classified as a behavioural or attitudinal process (Fiske & Taylor, 1991; Herscovitch & Meyer, 2001; Keisler, 1971; Weick, 1995). Behavioural-orientated studies have tended to refer to Becker (1960), Keisler (1971), Salancik (1977a) or Staw's (1977) definitions of commitment, while attitudinal-orientated studies refer to Buchanan (1974), Porter et al (1974) or Mowday et al's (1979) definitions of commitment.

The behavioural view of commitment, which focuses on actions, holds that behavioural commitment precedes, and therefore influences, attitudinal commitment (Staw, 1977). The

[11] Selection of the organizational commitment literature was carried out through a systematic three-step process to discriminate which parts of the literature were more closely related to the phenomena of interest of this study. This process followed guidance on justifying selection and omissions of the literature where the field contains a high volume of empirical research (Murray, 2002). This involved "setting explicit boundaries to the literature review… by favouring a well-informed selection of the literature instead of providing comprehensive coverage" (px).

First, a literature search was conducted and all organizational commitment research was initially screened. Second, organizational commitment research was reviewed. At this point, each paper or book was rated 1-3 in terms of its relevance to this study. Relevance ratings were scored as follows: 1 = high; 2 = medium; 3 = low. Third, a thorough review was conducted for those aspects of the commitment literature most relevant to the research questions (i.e. commitment to strategic change). This highlighted 'change commitment' constructs such as value commitment (Mayer & Schoorman, 1992), psychological commitment (Gaertner & Nollen, 1989), commitment to change (Herscovitch & Meyer, 2002; Fedor Caldwell & Herold, 2006) strategy commitment (Ford, Weissbein & Plamondon, 2003), and policy commitment (Foote, Seipel, Johnson & Duffy, 2005).

aim of the behavioural commitment research tradition has been to explain commitment as a course of action by identifying the conditions under which an act, once taken, will be likely to continue (Meyer & Allen, 1997: p49), in addition to identifying the "force which binds an individual to an entity or a course of action" (Meyer & Herscovitch, 2001: p308). Behavioural perspectives on commitment also tend to reiterate the congruence between the goals and objectives of the individual and the organization by focusing on the exchange or transaction which takes place between them in order for the goals and objectives of both to be achieved (Hberiniak & Alutto, 1972).

Becker's early work on commitment (1960) concluded that individuals engage in a consistent line of activity due to the perceived cost of doing otherwise (Randall et al, 1990). From the behavioural perspective, commitment is the result of a process by which people become psychologically bound to their actions in such a way that they feel a sense of personal obligation to follow through on the implications of those actions (cf. Kline & Peters, 1991; Salancik, 1977a). People become committed to the implications of their own actions to the extent that those actions are associated with three key perceptual states – volition, revocability, and publicness (Salancik, 1977b).

Volition refers to the perception that an action has been undertaken of free choice. When perceived volition is high, an individual should feel more personally responsible for an act than when perceived volition is low, and therefore, should feel a need to justify the wisdom of the choice made by behaving in a manner consistent with it (cf Kline & Peters, 1991).

Revocability refers to the perceived reversibility of an action. Salancik (1977a) argued that people undertake some actions on a trial basis because the perceived costs – tangible, psychological, or both – of revoking such acts are minimal. If things do not work out, they will try something else. People undertake other behaviours, however, believing that they will incur substantial costs by revoking their action. The more an individual perceives that behaviour cannot be reversed without high costs, the higher the commitment to the chosen course of action should be (cf Kline & Peters, 1991).

Publicness is the perception that significant others are aware of an action. Because public acts are known to significant others such as peers, behaviours that are inconsistent with them have stronger psychological implications than behaviour that is inconsistent with private acts. Thus, the more a person perceives significant others to be aware of an act, the more

committed the individual should be to the course of action consistent with it (cf Kline & Peters, 1991).

Salancik (1977a, 1977b) argues that commitment is a psychological obligation to behave in a manner consistent with the implications of prior behaviour. Acts will become committing and thus constrain future behaviour to the extent that people see them as undertaken by the exercise of free choice, not easily reversed, and known to significant others. Those three conditions represent high volition, low revocability, and high publicness. The irrevocability of the initial act, its publicness, and the volition associated with the act have been suggested as the conditions or "binding variables" (Keisler, 1971; Salancik, 1977a) of commitment.

Kiesler (1971) describes commitment emerging "where explicit behaviour, like an irrevocable decision, provides the pillar over which the cognitive apparatus must be draped" (p17). As Weick (1995: p156) summarizes, "once it becomes harder to change the behaviour than to change the beliefs about that behaviour, then beliefs are selectively mobilized to justify the act" (p156). This is done to avoid cognitive dissonance (Festinger, 1957), and maintain positive self-perceptions (e.g. as being "in control" or doing what one "wants to do" (Meyer & Allen, 1997: p10).

However, a number of commitment researchers have argued that organizational commitment is based on more than behavioural compliance, and the associated extrinsic rewards awarded in exchange for exerting effort on behalf of the organization: and instead place greater emphasis on the congruence between the individual's and organization's *values* (Porter et al, 1974; Gaertner & Nollen, 1989; Hall et al, 1970; Kidron, 1978; Mayer & Schoorman, 1992; O'Reilly & Chatman, 1986; Steers, 1977).

Buchanan (1974) encapsulates this view by defining commitment as "a partisan, affective attachment to the goals and values of an organization, to one's own role in relation to goals and values, and to the organization for its own sake, apart from its purely instrumental worth" (p533). Hence, the study of attitudinal commitment has typically involved the measurement of commitment as 'an attitude' or 'mindset', as it places greater emphasis on the psychological aspects of commitment. Namely, an employee's emotional attachment to, identification with, and involvement in the organization (Meyer & Allen, 1997).

From an attitudinal perspective, Porter et al (1974) defined organizational commitment as (1) the belief in and acceptance of organizational goals and objectives (2) the willingness to work

hard on behalf of the organization, and (3) definite intentions to remain in the organization. This definition was later updated by the same researchers (Mowday et al, 1979) as (1) a strong belief in and acceptance of the organization's goals and values, (2) willing to exert considerable effort on behalf of the organization, and (3) a strong desire to maintain membership[12]. Mowday et al's (1979) later definition suggests that cultural, moral, and individual-level factors are also important factors in the development of employee commitment to the organization. Mowday et al (1982: p26) succinctly make the following distinction between behavioural and attitudinal perspectives:

"Attitudinal commitment focuses on the processes by which people come to think about their relationship towards their organization. In many ways it can be thought of as a mindset in which individuals consider that their own values and goals are congruent with those of the organization…Behavioural commitment, on the other hand, relates to the process by which individuals become locked into a certain organization and how they deal with this problem."

The consequence of two different perspectives dominating the field is reflected in the specific foci of analysis that commitment researchers have studied, and the view that commitment is a uni-dimensional construct. For example, some researchers firmly place their analytical focus on 'goals' and behavioural commitment (Becker, 1960; Becker & Crandall, 1994; Benkhoff, 1997; Blau, 2003; Iverson & Roy, 1994; Keisler, 1971; Randall et al, 1990; Salancik, 1977a; Schaubroeck & Ganster, 1991), while others focus more on 'values' or 'mindsets,' and attitudinal commitment[13] (Buchanan, 1974; Jaussi, 2007; Kidron, 1978; Weiner, 1982).

This thesis does not aim to address the longstanding debate within the cognitive and behavioural psychology literatures around whether behaviour precedes attitudes, or vice versa (Fiske & Taylor, 1991; Salancik, 1977). However, it stands with the emerging consensus among many commitment researchers that commitment is multidimensional, takes different forms, and consists of *both* behavioural and attitudinal elements (Brooks & Wallace, 2006; Herold et al, 2008; Herscovitch & Meyer, 2001; Jaros et al, 1993; Meyer & Allen, 1997;

[12] There is a subtle distinction between both definitions, as Mowday et al (1979) place greater focus on the 'the strong belief in and acceptance of organizational goals and *values*' as opposed to Porter et al (1974), 'the belief in and acceptance of organizational goals and *objectives*'.

[13] Attitudinal commitment is also commonly referred to as affective commitment within the literature by those who study attitudinal commitment (e.g. Penley & Gould, 1988; Weiner, 1982).

Meyer et al, 1998; Mowday, 1999; Penley & Gould, 1988). It is this integrative perspective of commitment which is adopted as part of this thesis in developing a working definition of 'strategy commitment'.

Commitment is therefore viewed as a bipolar construct that is neither exclusively behavioural nor attitudinal, but consists of elements of both (Penley & Gould, 1988). Meyer & Allen (1997) accommodate this integrative perspective by framing commitment as a 'psychological state'. Initially, their terminology suggests favouring the attitudinal perspective. However, this is not the case. They state, "This [psychological] state can develop retrospectively (as justification for an ongoing action) as proposed in the behavioural approach, as well as prospectively (e.g. based on perceptions of current or future conditions of work within an organization) as advocated in the attitudinal approach" (p10).

Behavioural *and* attitudinal commitments are both important factors for successfully implementing strategic change. For example, behavioural commitment is critical in terms of actor's following a new set of tasks, new working practices, and new managerial processes to fulfil the strategic objectives of the organization (Balogun & Hope-Hailey, 2004; Johnson et al, 2008; Mintzberg et al, 2009; Pfeffer, 1998). Indeed, this is reflected in Porter et al (1974) and Mowday et al's (1979) conceptualisation of commitment by demonstrating the "willingness to work hard on behalf of the organization" (p226) and "exerting considerable effort on behalf of the organization" (p226).

However, as other commitment researchers have highlighted, instrumental or exchange processes by themselves do not offer a complete explanation of employee behaviour (Meyer & Allen, 1997; Smith et al, 1983; Steers, 1977; Penley & Gould, 1988; Weiner, 1982). Cartwright & Cooper (1990) have argued in relation to organizational commitment, that "acceptance may imply behavioural compliance, but not necessarily renewed organizational commitment" (p71).

In following this logic in relation to strategic change, behavioural compliance with strategy tasks does not necessarily imply acceptance, support, and commitment to the strategy (Barry & Elmes, 1997), as behavioural commitment alone (as expressed through compliant actions and based on instrumental means) does not necessarily infer commitment to 'the strategy'.

Although the role of instrumental, calculative, or exchange processes are not disputed in this thesis, behavioural commitment provides little indication as to whether actors identify or not with the espoused values of their organization's strategy (O'Reilly & Chatman, 1986; Penley & Gould, 1988).

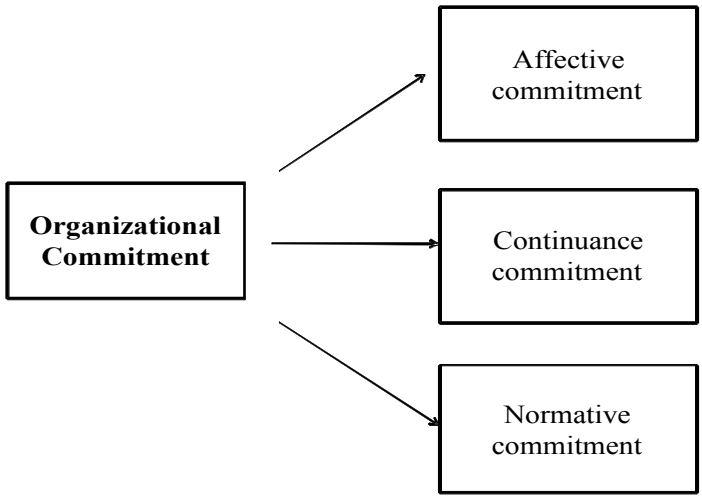
Similarly, attitudinal commitment is critical in terms of employees embracing strategic change (Argyris, 1998; Beer et al, 2000; Fiol, 2001; Hafsi, 2001; Kotter, 1995; Piderit, 2000). If there is no 'buy in' to proposed changes, then achieving successful strategic change becomes very difficult for organizations (Pfeffer, 1998; Shapiro, 2003). However, strategy execution requires action, and high employee attitudinal commitment on its own is unlikely to be sufficient to enable successful implementation (Herscovitch, 1999). Identification with the values of the strategy means little if the actions required to implement it are not forthcoming (Meyer & Allen, 1997). Value congruency, and the optimism and favour of supportive employees, must accompany activities which are aligned to strategic goals (Barnard, 1938).

Third, two commitment typologies that are acknowledged as having made key contributions to the organizational commitment field (Jaros et al, 1993; Mowday, 1999; Vanderberge et al, 1999), are those of Meyer & Allen (1991) and O'Reilly & Chatman (1986). Meyer & Allen's (1991) seminal work on commitment involved analyzing previous definitions of organizational commitment, and concluded that common to the various definitions is "the view that commitment is a psychological state that (a) characterizes the employee's relationship with the organization, and (b) has implications for the decision to continue membership in the organization" (p67). Their analysis formed the basis of the three component model of organizational commitment which incorporates *affective*, *continuance*, and *normative* dimensions of commitment (see Figure 3.2).

Meyer & Allen (1991) explain, "Affective commitment refers to the employee's emotional attachment to, identification with, and involvement in the organization. Employees with a strong affective commitment continue employment because they want to do so. Continuance commitment refers to an awareness of the costs associated with leaving the organization. Employees whose primary link to the organization is based on continuance commitment remain because they need to do so. Finally, normative commitment reflects a feeling of

obligation to continue employment, as employees with a high level of normative commitment feel that they ought to remain with the organization" (p67).

Figure 3.2 Three-component model of organizational commitment (Meyer & Allen, 1991)



Meyer & Allen (1991) argued that the nature of the psychological state attached to each form of organizational commitment is likely to differ when making distinctions between the three components. Meyer & Allen's (1991) three component model has arguably been the most influential in organizational commitment studies, as it identifies that organizational commitment can take different forms and is multidimensional (i.e. affective, continuance, normative). It has been applied in numerous studies of organizational commitment throughout the last two decades and has undergone the most extensive empirical evaluation to date (Meyer et al, 1993; Hackett et al, 1994; Irving et al, 1997; Jaros et al, 1997; Ko et al, 1997).

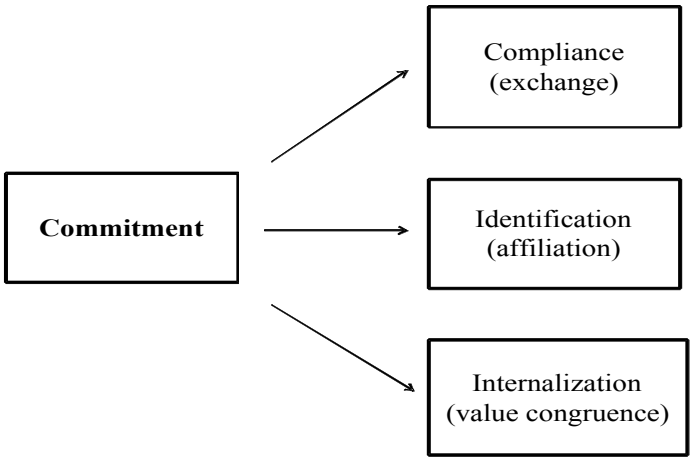
An alternative to Meyer & Allen's (1991) model is offered by O'Reilly & Chatman (1986). Like Meyer & Allen (1991), they believe that commitment reflects the "psychological bond" (px) that ties the employee to the organization, but O'Reilly & Chatman (1986) argue that the *nature* of the bond between an employee and organization can differ. Based on Kelman's (1958) work on attitude and behavioural change, they argued that commitment could take

three distinct forms: compliance (or exchange), identification (or affiliation), and internalization (or value congruence).

Compliance occurs when attitudes and behaviours are adopted not because of shared beliefs but simply to gain specific rewards. As such, public and private attitudes towards compliance may differ. *Identification*, in Kelman's terms, occurs when an individual accepts influence to establish or maintain a satisfying relationship; that is, an individual may feel proud to be a part of a group, respecting its values and accomplishments without adopting them as his or her own. *Internalization* occurs when influence is accepted because the induced attitudes and behaviour are congruent with one's own values; that is, the values of the individual and the group or organization are the same (cf O'Reilly & Chatman, 1986: p493).

Mowday (1999: p390) points out that there is some overlapping between Meyer & Allen's (1991) and O'Reilly & Chatman's (1986) typologies of commitment. For example, both represent commitment as multidimensional. However, O'Reilly & Chatman's (1986) typology offers greater utility for this thesis, particularly in relation to developing a working definition of 'strategy commitment'.

Illustration 3.2 Three-forms of commitment model (O'Reilly & Chatman, 1986)



The major limitation of Meyer & Allen's (1991) model – and by association, the majority of organizational commitment studies in which it has been applied - is its almost exclusive focus on the organizational objective of retaining employees. Meyer & Allen (1997) later

acknowledged this limitation by cautioning that employee retention is not the organization's only goal, adding, "Most organizations – and most managers – want much more from committed employees than simply their continued membership in the organization" (p64). Yet little attention is ever given to employee commitment to the organization beyond their allegiance, loyalty, and membership. As a consequence, employee's commitment to the organization during episodes of strategic change, and more importantly, their commitment to the content or process of strategic change which the organization may be undertaking, is absent from those organizational commitment studies which draw upon Meyer & Allen's model (Fedor et al, 2006; Herold et al, 2007).

Meyer & Herscovitch (2001) later developed Meyer & Allen's (1991) three component model into "a general model of workplace commitment" (p299). They followed the approach by other commitment researchers who had gradually begun to acknowledge that there are multiple foci of commitment beyond just commitment to 'the organization' (Becker et al, 1993; Reichers, 1985). Meyer & Herscovitch (2001) advocated the application of affective, continuance, and normative commitment to 'commitment to organizational change' using several measures. As with other quantitative approaches employed in organizational commitment studies, the '*how'* and '*why'* of Meyer & Herscovitch's (2001) commitment to change dimensions cannot be captured due to the positivist design of their commitment to change scale.

In summary, O'Reilly & Chatman's (1986) model provides a better theoretical framework for this thesis from which to examine the relationship between strategy commitment and strategy legitimacy for several reasons. It offers greater scope to explore *the basis* of actor's commitment towards the strategy from a qualitative perspective, which Herscovitch & Meyer's (2001) work commitment scales fail to achieve due to their quantitative methodological orientation. It also better accommodates the need to consider both the behavioural and attitudinal forms of commitment (Penley & Gould, 1988), with the attitudinal elements of their *identification* and *internalization* categories, in addition to the behavioural elements of their *compliance* category.

O'Reilly & Chatman's (1986) model offers greater adaptability to examine issues beyond commitment to the organization, namely, commitment to 'the strategy'. The three dimensions of *compliance, identification*, and *internalization* can be better applied or adapted to studies of strategic change than Meyer & Allen's (1991) dimensions of affective, continuance, and

normative commitment. The 'identification' and 'internalizing' dimensions of commitment are recognized as critical to successful strategic change. For example, Quinn has highlighted that "when people do not internalize an adequate range of goals, the consequences can be extremely costly" (Quinn, 1980: p85). He also points to the need for top management to "generate identity with emerging strategies" (p135).

3.2.3 Change commitment discourse

Although studies (and definitions) of commitment in the organizational behaviour literature over the last three decades have, in general, only related to commitment to 'the organization' (Meyer & Allen, 1997; Mowday et al, 1979; Porter et al, 1974), some have argued that attachment and positive associations between employees and their organizations can also be represented through change events (Fedor et al, 2006). This perspective has been reflected in an increasing number of empirical studies choosing to focus on employee commitment within organizational change contexts (Caldwell et al, 2004; Fedor et al, 2006; Foote et al, 2005; Ford et al, 2003; Gaertner & Nolan, 1989; Herold et al, 2007; Herold et al, 2008; Herscovitch & Meyer, 2002; Mayer & Schoorman, 1992).

For example, Gaernter & Nollen (1989) explored the relationships among career experiences, perceptions of company employment practices, and *psychological commitment* to the firm, arguing the importance of ascertaining the effects of employee perceptions of company employment practices within a manufacturing firm. They defined psychological commitment as "non-instrumental attraction to and identification with the goals and values of the organization...excluding propensity to stay with the organization." Gaertner & Nollen (1989) distinguish psychological commitment from Meyer & Rowan's (1991) continuance and normative commitment constructs which are concerned with an employee's intentions to stay with the organization.

Gaertner & Nollen (1989) found that employee perceptions of the organization's adherence to career-orientated employment practices, including internal mobility, employment security, and training and development, were more strongly related to psychological commitment than other characteristics of the work context such as participation, supervisory relations and instrumental communication. Gaernter & Nollen's (1989) research explores the construct of commitment from a psychological aspect. However, the analytical focus is limited to career experiences and company employment practices, and the construct of psychological commitment is not examined within the context of strategic change. Hence, the congruence

between individual values and organizational values which guided or determined strategic action was not explored.

Mayer & Schoorman (1992) examined *value commitment* based on March & Simon's (1958) theory which proposed that employees make two distinct, ongoing decisions about an organization: to participate, and to produce or perform, whereby "decisions by workers to participate in an organization reflect different considerations from decisions to produce" (March & Simon, 1958: p83). The considerations that lead to decisions to produce include the strength of an employee's identification with the goals and values of the organization.

Mayer & Schoorman (1992) defined value commitment as "a belief in and acceptance of organizational goals and values and willingness to exert on behalf of the organization." This is the same definition produced by Mowday et al (1979), however, Mayer & Schoorman (1992) argued that individuals who are 'value-committed' "should be expected to engage in behaviours that would help the employing organizations achieve its goals…and likely to engage in behaviours helpful to the organization regardless of whether or not they are an expected part of the person's role" (p673).

Neubert & Cady (2001) introduced *program commitment* as a distinct commitment construct in a multi-study longitudinal investigation involving a political organization recruiting new members, and a university embarking on a quality improvement initiative. Neubert & Cady (2001) conceptualise program commitment as "a measure of attachment to a specific program or initiative of planned scope within the organization," as opposed to the global attachment to the organization as an entity, common to most organizational commitment studies. Program commitment also differs from goal commitment in that program commitment is a psychological attachment to the overall goals of a program rather than commitment to individual performance goals.

Neubert & Cady (2001) examined the relationship of program commitment to behavioural outcomes including participation and performance, and to identify their potential antecedents, in order to establish what might be done to increase commitment to organizational programs. In the first group associated with the recruitment of new political members, a sample size of 181 participants responded to two different surveys over a two-month time period. Each participant was charged with increasing membership of the organization. Neubert & Cady (2001) found that program commitment was positively related to participation in the program (i.e. attending campaign meetings, contacting potential members through sales calls), and in

turn affected program-related performance (i.e. recruiting more members for the organization, the number of new people who signed up for membership and paid annual dues during the two-month study period following participant contact).

In the second group associated with the quality improvement initiative, Neubert & Cady (2001) hypothesized that with rewards, managers, and co-workers' behaviours would be positively associated with program commitment, and that those employees high in affective variables such as organizational commitment, change efficacy, and teamwork orientation would be more likely to be committed to the change program. From a sample of 131 respondents, Neubert & Cady (2001) results indicated that organizational commitment, change efficacy, and teamwork orientation were all antecedents to program commitment. They also found that initial program commitment mediated the relationship of Time 1 variables to program commitment in later stages of the organizational initiative.

As initial program commitment in Time 1 is the strongest predictor of subsequent commitment, Neubert & Cady (2001) emphasized the importance of gaining commitment early in program initiatives. They also argued that where pre-existing individual differences fit with the characteristics of a program (i.e. teamwork orientation), this makes change psychologically more attractive and to some extent makes each be dependent on an individual's perceived personal fit with the program.

Neubert & Cady (2001) recommend human resource professionals select program participants that fit a program's espoused values. However, in doing so, they fail to acknowledge that many organizations tend to be tied to contractual arrangements with their employees, and cannot easily dismiss those who are 'non program-compatible', particularly in unionized environments (Ferlie, et al, 2002). As with other change-related commitment constructs, both program initiatives in Neubert & Cady's study do not appear to explicitly equate to a radical change in organizational strategy on a vertical and horizontal level (Bartunek & Moch, 1987), and therefore, arguably do not constitute being categorized as strategic change on a wide scale. Furthermore, in Study 1, data was collected over a period of two months which is a relatively short and brief part of any strategy process. Therefore, considering this case as a longitudinal study is open to challenge.

Ford, Weissbein & Plamondon (2003) examined whether *strategy commitment* was distinguishable from the more general construct of *organizational commitment*. They focused specifically on strategy commitment and evaluated the performance of work behaviours that

were consistent with the new strategy being adopted. Ford et al (2003) studied the introduction of a community-policing initiative across eleven police departments within a region which was looking to expand the initiative across all regional police departments to create a shift in philosophy towards community-policing.

From a sample of 324 police officers, self-reporting surveys were completed, consisting of seven measures which included the reporting of strategy-related behaviour, job satisfaction, strategy commitment, organizational commitment, managerial support, job context, and job experience. Ford et al (2003) found that organizational commitment and commitment to a strategy to be distinct constructs, and that individuals who were initially involved in the change effort were more likely to be committed to the strategy, and more likely to try out strategy-consistent behaviours on the job.

Ford et al's (2003) study is particularly important to this thesis for two reasons. First, from a conceptual perspective, a clear distinction is made between commitment to 'the strategy' and commitment to 'the organization' as two distinct constructs. This is important when incorporating the concept of commitment into strategic change research. Ford et al (2003) argued that commitment to a new strategic direction is likely to be affected by an individual's work or job experience, and the events that the individual experiences during the performance of the job. They contend that differentiating between commitment to 'the organization' and commitment to 'the strategy,' could help understand better the relationship between the move to a new strategy and key outcomes such as job attitudes and work behaviour.

Second, methodologically, Ford et al (2003) use two measures which provide utility for this thesis: strategy-related behaviour and strategy commitment. Strategy-related behaviour reflects the behavioural view of commitment, whilst strategy commitment reflects a stronger attitudinal component. Strategy-related behaviours are those behaviours which are identified as desirable within the strategy plan and philosophy of community policing. These consisted of attending youth programs, working to solve problems in the community, making presentations to community groups, making door-to-door contacts with citizens, religious groups, and businesses regarding quality of life and crime prevention issues. Strategy commitment focused on the extent to which police officers supported the strategy, and the extent to which they believed it could work. In doing so, Ford et al (2003) appear to follow the retrospective and prospective view of commitment (Meyer & Allen, 1997).

Foote, Seipel, Johnson & Duffy (2005) examined the influence of attitude, role clarity, and role conflict on *policy commitment*, as well as the influence of policy commitment on citizenship behaviour. They defined policy commitment as, "the belief in, and proactive endorsement of specific major organizational initiatives, or courses of action (i.e.) policies that embody the values resident within the organization" (p204).

From a sample of 148 production workers and lower-level supervisors in a manufacturing plant who completed a self-reporting questionnaire, employees' commitment was assessed concerning a new policy to implement team-based structures, which contrasted to the company's approach of the previous thirty years, where strongly embedded hierarchical structures had been in place. Foote et al (2005) found that attitudes and role clarity positively influenced policy commitment, and that policy commitment positively influenced conscientiousness and civic virtue dimensions of citizenship behaviour to the extent that employees had a tendency to exhibit extra-role behaviours on behalf of those polices.

Based on these results, Foote et al developed a model which they argued indicated that a positive attitude and a clear understanding of one's role can predict policy commitment, and that policy commitment is predictive of conscientiousness and civic virtue behaviours. Central to this model, is the assumption that organizations consist of rational actors who are predictable when manipulated by positive or negative forces (Lewin, 1951), and therefore, management's expectations of which organizational policies will succeed is likely to be dependent on understanding the positive and negative psychological forces (e.g. motivations) acting on their employees with regards to those polices (Diamond, 1992).

Foote et al's (2005) policy commitment construct is useful to this thesis in terms of the emphasis placed on endorsement and support of policy because it leans towards issues of legitimacy and the approval of organizational action. However, the methods employed to establish why participants supported or endorsed policy places limitations on the depth of the data and the persuasiveness of the study's findings. Policy commitment was measured using four items of the Occupational Commitment Questionnaire (Porter et al, 1974) and three items from Meyer & Allen's three-component commitment model (1991, 1993). These consisted of seven statements, and all respondents were asked to indicate their agreement with each statement on a seven-point Likert-type scale ranging from strongly disagree to strongly agree. Of those who supported the policy, there was little scope to carefully examine in any real depth their strategic reasoning for doing so (Regner, 2003). Actors' responses

offer no insight as to *why* policy was being endorsed. This also pertains to those respondents who did not support the policy, for reasons other than role conflict and role clarity.

Furthermore, participants' appraisals of whether to endorse the restructuring policy appear to have been assessed retrospectively, as opposed to data being collected in real-time (Johnson et al, 2007). Like other commitment researchers who adopt quantitative methods, Foote et al (2005) acknowledge the limitations in trying to seek causal explanations that underpin or form the basis of actors' attitudes, yet they maintain that their findings indicate that behavioural compliance reflects support and approval of organizational action. However, as highlighted earlier, the issue of behavioural compliance indicating attitudinal support remains open to dispute among commitment researchers (Cartwright & Cooper, 1990; O'Reilly & Chatman, 1986).

Fedor, Caldwell & Herold (2006) examined individuals' willingness to support and work on behalf of the successful implementation of organizational change, and how organizational practices associated with implementation influenced individuals' commitment to the organization. They investigated the relationship between *change commitment* and two different commitment responses: *change fairness* and *change favourableness*. They argue that these two responses, which are taken from the organizational justice literature (Brockner, 2002; Kim & Mauborgne, 1992), are best understood via a three-way interaction between the overall favourableness (positive / negative) of the change for work unit (department) members, the extent of the change in the work unit, and the impact of the change on the individual's job.

Covering a sample of 806 employees from thirty-four US organizations across a variety of industry sectors, both private and public, including technology, manufacturing, government, energy, healthcare, and financial services organizations, thirty-four change events were identified ranging from nine reorganizations or restructuring initiatives, eight implementations of new technology or reengineering projects, as well as several mergers / consolidations of units, and changes in leadership, and strategy. The main finding of the study was that commitment to change and commitment to the organization was not impacted in the same way by organizational change events. Like Ford et al (2003), they differentiated commitment 'to change' with commitment 'to the organization'. They also found that individual reactions to change are based on a "complex calculus reflecting different aspects of the change and its consequences" (p20).

Highest levels of commitment occurred when there was a considerable amount of change happening at the work unit level but when the demands placed on the individuals were low. The researchers deducted, "it is as if employee's welcome favourable change, especially when they do not have to make a significant investment in adjusting to the change" (p20). They also suggested, when adaptation requirements are low, the change is embraced more so than when adaptation requirements are high, even when the change is generally favourable. Fedor et al (2006) concluded that operationalizing change simply in terms of its impact on either the individual or the work unit by itself was insufficient, and accounting for the extent of change occurring across multiple levels of analysis was needed in order to better understand individuals' reactions.

The phenomena of interest of Fedor et al's (2006) study is relatively similar to this study as it examines actor's responses to organizational change, and their degree of adaptability and intentions to support strategic goals. However, although the study incorporates thirty-two change events, it is not explained how each of these change events differ in nature and scale. The researchers do acknowledge that different types of change can produce very different reactions and cause different levels of responses or upheaval, but despite referring to 'significant' change as differing to other smaller scale changes, they group all these change events together regardless as if they were all homogenous. Therefore, the generalizability and impact of this study's findings in the context of strategic change is somewhat limited.

Unlike most commitment-related studies which attempt to be predictive, this study is retrospective. Fedor et al (2006) conclude that their results support the view that personal adaptation demands "create the uncertainty, fear of failure, or difficulty in sensemaking that are thought to drive negative attitudes toward change" (p25). Sensemaking is retrospective (Weick, 1995), however, it is questionable whether Fedor et al can make claims around the nature and content of sensemaking when actor's responses are framed through quantitative Likert-type questionnaires which excludes the possibility of variables (or casual explanations to responses), other than those framed by the researchers. Furthermore, no evidence of social interaction, which is a key component of sensemaking in shaping attitudes (Weick 1995), is described as taking place between those employees from each of the thirty-four organizations included in the sample.

Herold, Fedor & Caldwell (2007) explored the linkages between change reactions and the context in which the changes occur simultaneously by investigating the relationship between

context, individual differences, and employees' commitment to a change. They examined the degree to which change self-efficacy - defined as "a set of beliefs about one's ability to meet a given set of situational demands" (p943) – and change turbulence or the setting within which the change occurs (i.e. the extent of other changes going on at the same time) may be related to individuals' commitment to the change.

Drawing on the strategy literature focusing on turbulent external environments (Dess & Beard, 1984; Lawrence & Lorsch, 1967) and issues of procedural justice and fairness within organizational change (Brockner, 2002), Herold et al (2007) suggested that having to respond to additional distractions going on in the organization at the same time as the focal change could be expected to frustrate individuals. High change self-efficacy is offered as a coping resource that during a change situation may result in greater commitment or willingness to support that change, especially in environments characterized with simultaneous or overlapping changes.

Data was collected from 593 employees of twenty-five organizations from across finance, manufacturing, education, consumer products, and high technology sectors. Changes represented included work process changes (30%), new technology implementations (30%), reorganization (11%), with the remaining 29% divided among strategy changes, relocations, outsourcing, leadership changes, and downsizing. Herold et al (2007) found that individual differences in change efficacy can affect one's commitment to change and that individual differences in change efficacy interact with the turbulence of the change setting to influence change outcomes, such as commitment. They also found that an environment of pervasive change may negatively influence individuals' commitment to a given change, especially for those with low efficacy in dealing with change. For individuals who are high in change self-efficacy, such turbulent environments do not seem to be as problematic.

Herold et al's (2007) study includes individual level measures consisting of change turbulence, fairness of the change process, work unit impact (i.e. the degree to which the change disruptions in the work processes, procedures, or routines in the work unit) and group level measures including change commitment, change self-efficacy, and personal job impact. In practice, only one individual level measure in the study assessed 'change commitment' which consisted of four items. Sample items included 'I am doing whatever I can to help this change be successful' and 'I have tried (or intend to try) to convince others to support this change'. As this measure forms only a small part of the Herold et al's (2007) study, the

conclusions which can be drawn in relation to strategy commitment (Ford et al, 2003) are debatable.

Similar to the researchers' previous study (Fedor et al, 2006), the number of change events incorporated in the study are mentioned but the nature and scale of the change events are not described in detail, particularly in relation to strategy changes. However, an important contribution of this change commitment study was Herold et al's (2007) emphasis on the need to consider the context of change in commitment studies. Although this message has long been echoed from within the strategy field (Balogun, 2006; Pettigrew & Whipp, 1991), the researchers raise an important point for commitment researchers to take account of when conducting commitment studies concerning organizational change.

In summary, Section 3.2 has illustrated the broad usage of commitment within strategic management, organizational commitment, and change commitment discourses. It demonstrates the variance associated with the concept of commitment when it is employed across these discourses where meanings differ, thereby, highlighting the potential interpretative problems it creates for both strategy researchers and practitioners.

It reinforces the need for conceptual clarity when examining commitment within the context of strategic change, and demonstrates how the concept can be easily misconstrued and interpreted quite differently by strategy researchers and practitioners. It also highlights that there is an opportunity to combine strategy and commitment discourses by proposing that the concepts of 'strategy-related behaviour' and 'strategy attitudinal commitment' can together provide the basis of a clear definition of 'strategy commitment'.

A significant contribution of change commitment discourse to this thesis is this group of researchers application of the concept of commitment within change-related contexts, and by making clear conceptual and empirical distinctions between commitment 'to change' versus commitment 'to the organization'. However, most change commitment studies lack descriptive qualitative data which explores the basis of actors' commitment. Furthermore, middle manager change commitment has not been studied (Balogun et al, 2007).

The strategic change literature has yet to significantly incorporate current conceptualisations of change commitment from the commitment field (Foote et al, 2005; Ford et al, 2003; Herold et al, 2007; Herscovitch & Meyer, 2002; Neubert & Cady, 2001). Similarly, there are many aspects within the strategic change literature which change commitment researchers do

not incorporate or acknowledge such as those highlighted by strategy-as-practice researchers including the importance of organizational and institutional contexts (Balogun, 2006; Johnson et al, 2007; Pettigrew, 1992; Scott, 2001; Whittington, 2006). Although strategic change and change commitment discourses are inter-related in terms of their focus on change, they are not so well connected in terms of common language and terminology.

This issue is likely to be a contributing factor to the conceptual clarity problems which Meyer & Allen (1997) and Mowday et al (1982) refer to which was highlighted in this section's introduction. There is a need for strategy researchers to be more precise in their deployment of the term 'commitment' in the same way that change commitment researchers within the applied psychology field have done in response to calls from Becker et al (1993) and Reichers (1985) to be more precise about the foci and targets of commitment.

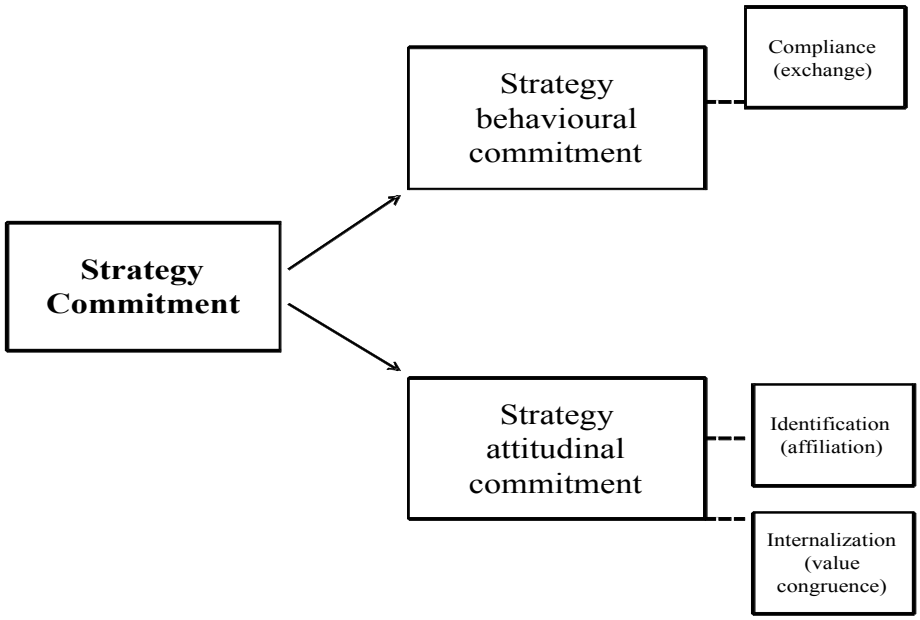
3.2.4 Defining strategy commitment

> "Strategy commitment is a bipolar construct which consists of both behavioural and attitudinal components which are *strategy-related behaviours* and *strategy attitudinal commitment*. Strategy commitment is commitment to 'the strategy' content and the change process required for its implementation."

The theoretical basis of this definition draws firmly on the commitment literature and takes cognisance of the current conceptualisations of commitment within strategy discourse, for example, the foci of commitment towards either 'the organization' or 'the strategy,' and the different perspectives offered on commitment as a behavioural or attitudinal process.

The definition incorporates the three elements of O'Reilly & Chatman's (1986) model: compliance, identification, and internalization. Strategy behavioural commitment (SBC) captures the compliance element of the framework, while strategy attitudinal commitment (SAC) captures identification and internalization elements of the framework.

Figure 3.2.4 Illustration of the dimensions of strategy commitment



Ford et al (2003) first introduced the concept of *strategy commitment* in their study on implementing a community policing strategy. Therefore, the concept of 'strategy commitment' is not unique to this study. However, Ford et al's (2003) conceptualization of strategy commitment is not explicit enough in incorporating both behavioural *and* attitudinal elements of commitment.

This thesis conceptualizes commitment as a bipolar construct which supports the *internalization* and *identification* elements of O'Reilly & Chatman's (1986) model through the concept of 'strategy attitudinal commitment', while the *compliance* element of their model reflects the concept of 'strategy-related behaviours' (Ford et al, 2003). In effect, strategy commitment is viewed in this thesis as multidimensional.

The concept of 'change commitment' is highlighted as being useful in helping to explain how actors commit to organizational change and the basis of their commitment to change (Foote et al, 2005; Herold et al, 2007). In particular, the concept of 'strategy commitment' - i.e. strategy-related behaviour - introduced by Ford et al (2003) - is of use to this study in

examining actor's commitment from a behavioural perspective. However, there is also a need to recognize the attitudinal component of strategy commitment as O'Reilly & Chatman's (1986) model does.

Strategy commitment concerns commitment to 'the strategy' and not 'the organization,' as the latter has tended to be the dominant focus of analysis in commitment studies, and a great deal in already known about commitment to the organization (Meyer & Allen, 1997). It is acknowledged that organizational commitment and strategy commitment may be related, however, they are also conceptually distinct. This view is supported by recent empirical studies that provide a strong argument for distinguishing strategy commitment (or change commitment) from organizational commitment (Herscovitch & Meyer, 2002; Ford et al, 2003; Foote et al 2005; Fedor et al, 2006).

Therefore, for the purposes of analysis, this thesis sets out to examine 'commitment to the strategy' and not 'commitment to the organization'. This definition of *strategy commitment* delineates strategy commitment from organizational commitment, and responds to the need for conceptual clarity when examining commitment within the context of strategic change (Mowday, 1999).

3.3 Chapter Summary

This review of the legitimacy and commitment literature has illustrated the range of legitimacy and commitment constructs which fill strategy and management discourse. The lack of conceptual clarity in the strategy literature in particular, around which legitimacy and commitment constructs are being linked to assert reciprocity, raises a critical question about the strength and credibility of the normative view.

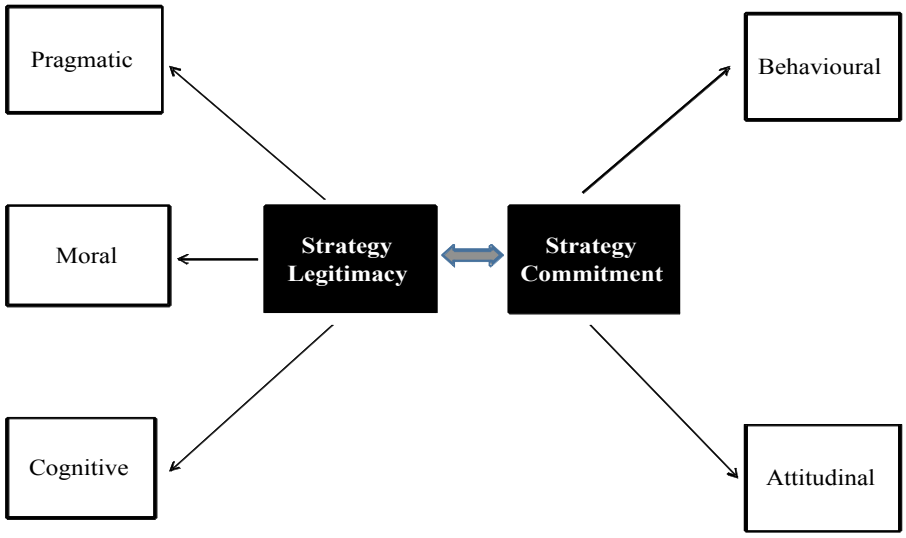
Whilst strategy researchers remain non-specific about which legitimacy and commitment constructs they are drawing upon to assert reciprocity, the basis of the normative view remains open to question. This ambiguity reflects those conceptual problems which legitimacy and commitment researchers have long expressed concerns about (Meyer & Allen, 1997; Suchman, 1995; Vaara et al, 2006).

Studies which cite a reciprocal relationship between legitimacy and commitment have also failed to fully recognize or acknowledge the multidimensional nature of legitimacy and commitment, or that different legitimacy and different commitment constructs fill the

strategic change process, and that these different types of legitimacy and commitment constructs potentially have very different relationships.

The examination of both strategy legitimacy and strategy commitment as multidimensional constructs may be critical in developing a deeper understanding of the nature and complexity of the legitimacy-commitment relationship. Those dimensions of strategy legitimacy and strategy commitment which are employed in this thesis are illustrated in Figure 3.3.1

Figure 3.3.1 Dimensions of strategy legitimacy and strategy commitment



Finally, strategy-as-practice researchers have been encouraged to be clear about the objectives of their research, and the 'so what?' that comes from it (Balogun et al, 2007: p203). It is argued that the nature of the legitimacy-commitment relationship during strategic change is important from a strategy-as-practice perspective on three levels.

First, although several strategy-as practice studies have highlighted legitimacy and commitment-related issues (Jarzabkowski, 2005; Jarzabkowski & Sillince, 2007; Laine & Vaara, 2007; Mantere, 2007; Mantere & Vaara, 2008; Reger, 2003), to date, there are no practice studies which have attempted to explore the legitimacy-commitment relationship at a micro-level of analysis from the perspective of middle managers.

Second, the strategy legitimacy-commitment relationship has yet to be examined from the perspective of middle managers when strategizing in umbrella contexts. Third, what middle managers *do* when strategizing under umbrella conditions, as they evaluate legitimacy and commitment issues (i.e. the middle manager dilemma:' is this the right thing to do, and will I go along with it?'), may be consequential for firm outcomes (Jarzabkowski et al, 2007; McKinley & Scherer, 2000).

This thesis sets out to examine the thinking practices (Melin, 2007) and strategizing activities (Johnson et al, 2003) of middle managers, namely, how they confer legitimacy, and commit to, strategic change in umbrella contexts (Mintzberg & Waters, 1985). Based on their real-time evaluative appraisals and narratives, this study analyzes the strategy legitimacy-commitment relationship from the perspective of those outside of top management teams. It considers how the deliberate-emergent conditions of umbrella strategies influence strategists' legitimacy-commitment appraisals, and examines the effects of their practices at firm-level as a means of explaining strategic change outcomes.

It is these issues which therefore lead to three central research questions:

1) What is the nature of the relationship between strategy legitimacy and strategy commitment from the perspective of middle managers as change unfolds?

2a) Do umbrella strategy conditions influence the conferring of strategy legitimacy and attainment of strategy commitment?

2b) If so, how do umbrella conditions, and legitimacy-commitment issues, subsequently shape middle manager's practices?

3) How are middle managers' practices consequential for umbrella strategy outcomes?

CHAPTER 4

METHODOLOGY

This chapter includes the following:

i. Research design and methodology
ii. The case study background
iii. Data collection and sampling strategy
iv. The data analysis process

4.1. RESEARCH DESIGN AND METHODOLOGY

The ontological position adopted for this study is subjectivist as reality is understood to be a socially constructed phenomenon (Berger & Luckmann, 1967). Social reality is subject to a continuous process of ongoing negotiation and alteration (Czarniawska, 2003) as opposed to the realist assumptions of stability and permanency which objectivist ontology offers (Comte, 1853; Donaldson, 2003).

The epistemological orientation of this research follows an interpretivist approach (Burrell & Morgan, 1979: Gioia & Chittipeddi, 1991) as a positivist line of inquiry does not fully account for the subtleties, nuances, and complexities of organizational life (Bailey et al, 2009; Hatch, 2005). Furthermore, positivist approaches are known to fail to recognize the wider social context in which strategizing takes place (Hendry, 2000: Whittington, 1993). These ontological and epistemological positions reflect, and are consistent with, the broader strategy-as-practice agenda (Jarzabkowski et al, 2007: p20).

An in-depth, longitudinal qualitative case study (Yin, 2003) was carried out in real time (Denis et al, 2001; Pettigrew et al, 2001) across three distinct time periods during the first year of the development and implementation of an umbrella strategy (Mintzberg & Waters, 1985). Methodologically, strategy-as-practice research has tended to follow the process tradition (Johnson, 1987; Langley, 1999; Mintzberg, 1990; Pettigrew, 1992) by adopting qualitative, longitudinal methods that take seriously the importance of context, and how things change and evolve over time. Indeed, qualitative data is regarded as "a central requirement" for developing the strategy-as-practice perspective (Johnson et al, 2007: p52).

Qualitative approaches feature in only a few commitment studies (Alatrista & Arrowsmith, 2004), as commitment researchers have traditionally followed positivist methodologies (Blau,

2003; Mathieu & Zajac, 1990; Randall et al, 1990). Meyer & Allen (1997) champion the predictive abilities of organizational commitment research, yet the methodological limitations of quantitative methods are repeatedly highlighted by the 'change commitment' research community (Foote et al, 2005; Ford et al, 2003) even though such methods continue to be applied to organizational and change commitment research.

Longitudinal approaches have frequently been used in legitimacy-related studies (Elsbach, 1994; Kostova & Zaheer, 1999; Kumar & Das, 2007), although commitment researchers have increasingly argued for the need to conduct more longitudinal studies to capture actor's level of commitment at different points in time, which change commitment research has so far failed to do (Beck & Wilson, 2005; Fedor et al, 2006; Foote et al, 2005; Mowday, 1999). A longitudinal approach is adopted in this study to capture the emergent and unpredictable elements of strategic change which unfold over time (Johnson & Balogun, 1998; Pettigrew et al, 1992; Van de Ven, 2005), but also to provide the complex set of historical and contextual data that are necessary for understanding strategizing (Rouleau, 2005).

4.1.1. Sensemaking and narrative in strategic change

The theoretical bases for studying strategizing in this thesis are sensemaking (Weick, 1979, 1995) and narrative theories (Barry & Elmes, 1997). These theories have been selected for several reasons. First, sensemaking is a social activity that is triggered by something unusual, unexpected, or important, and in situations that are unfamiliar and not routine (Weick, 1995; Vaara, 2003). It is an ongoing cognitive process (Weick et al, 2005) that involves the reciprocal interactions of information- seeking, meaning ascription, and action as actors attempt to understand and decipher the meaning of events around them (Dutton et al, 1983; Gioia & Chittipeddi, 1991; Thomas et al, 1993; Weick, 1979).

Sensemaking occurs "when the current state of the world is perceived to be different from the expected state of the world...and a shift occurs to make sense of the disruption" (Weick et al, 2005: p409). Actors attempt to make sense of disruptions by searching for "reasons" which are pulled from frameworks such as institutional constraints, organizational premises, plans, acceptable justifications, and traditions inherited from predecessors (Weick et al, 2005: p409).

Sensemaking processes have been shown to be important during strategic change (Balogun & Johnson, 2004, 2005), mainly because change issues tend to "provoke the attention of

organizational members" (Dutton et al, 1991: p518). Change issues can often be ambiguous and uncertain for managers (Gioia & Chittipeddi, 1991; Dutton et al, 1991). To cope with this ambiguity and uncertainty, managers search for meaning and plausibility as they attempt to make sense of the information and events surrounding change (Gioia & Thomas, 1996; Rouleau, 2005; Weick et al, 2005). Furthermore, when managers are on the receiving end of change they construct an interpretation of the implications it has for them (Balogun, 2003; Bartunek et al, 2007; Gioia & Chittipeddi, 1991).

In this thesis, the concept of sensemaking is taken to mean a number of things. It is the nature of manager's interpretations, their evaluations and appraisals of the strategy content and process (Gioia et al, 1994), their arguments (Weick, 1995) or 'strategic reasoning' (Regner, 2003), and their meaning-making when socially interacting with others involved in the strategy process (Rouleau, 2005) - all of which are expressed through language and talk (Weick et al, 2005). Researchers have previously noted that sensemaking is affected by the context in which it occurs (Weick, 1979; Gioia et al, 1991), especially where complex socio-political processes are involved in strategic change (Vaara, 2003). It plays a central role in the "cognitive reorientation" (Gioia & Chittipeddi, 1991: p363) required from second-order strategic change (Bartunek, 1984), which is the type of change this case study's organizations were undergoing.

Second, a narrative approach to the study of strategizing follows the 'linguistic turn' in practice research (Alvesson & Karreman, 2000). Narrative approaches have become increasingly prevalent in studies of strategic change (Balogun et al, 2007), and have been used to study managerial identity (Beech & Johnson, 2005), managers interpretations of regulative changes in financial markets (Dunford & Jones, 2000), middle manager 'issue-selling' (Rouleau, 2005), biographical accounts of strategy practices (Rouleau, 2004), and change recipient participation during strategic change (O'Connor, 1995, 1996).

A narrative strategy involves the construction of a detailed story from the raw data (Langley, 1999), and in its most basic form, requires at least three elements: an original state of affairs, an action or an event, and the consequent state of affairs (Czarniawska, 1998: p2). Narrative provides an interpretative account of sequential events as they unfold over time (Boje, 2001; Czarniawska, 1998; Gabriel, 2000). It is sensitive to the ongoing character of change (Tsoukas, 2005), where the temporal order of events plays an important role (Langley, 1999). It requires 'a plot' to help events make sense (Polkinghorne, 1995; Vaara, 2002), therefore, it

places a strong emphasis on chronology in order to help bring these events into "a meaningful whole" (Czarniawska, 1998: p2). Narratives are not only a legitimate form of explanation, but also an appropriate vehicle for repositioning actions and events in organizations (Van Maanen, 1988).

Narratives become important during strategic change as "stories about directionality are variously appropriated, discounted, championed and defended" (Barry & Elmes, 1997: p 432). Narrative analysis is regarded as a subset of interpretative discourse analysis (Hardy, 2001), and it provides the opportunity for researchers to uncover more about the micro-level aspects of strategic change (Beech & Johnson, 2005). Discursive approaches have proven particularly useful towards improving our understanding of the nature and complexity of organizational change, especially concerning issues pertaining to the role of agency (Tsoukas, 2005).

Central to the narrative approach is the inclusion of different narratives of the same organizational change (Brown & Jones, 1998; Vaara, 2002), which places emphases on the "simultaneous presence of multiple, interlinked realities.... [that] captures the diversity and complexity present in strategic discourse" (Barry & Elmes, 1997: p430). These multiple realities present dialogical accounts with are dynamic and often conflicting as opposed to a monological account that presents a single perspective of a dominant group (Heracleous & Barrett, 2001: Laine & Vaara, 2007). Narratives are also important devices for the expression of political activity during strategic change, where ideas, motives, and practices are rationalized, justified, and legitimated (Currie & Brown, 2003; Dawson & Buchanan, 2005: Vaara & Tienari, 2002).

Barry & Elmes (1997) have urged researchers to attend more closely to the socio-cultural contexts from which strategies arise, as narratives cannot be fully understood without consideration to the social context in which they occur (Laine & Vaara, 2007). Such concerns about the importance of broader contextual factors in strategy research are considered to be critical from a strategy-as-practice perspective (Whittington, 2006).

In this thesis, narrative analysis is used as part of an inductive-theory building process (Langley, 1999; Walcott, 1994). From a research process perspective, it also used as a 'sensemaking device' to help organize and theorize a large volume of qualitative data (Langley, 1999; Weick, 1979). From a data collection standpoint, it serves an important reflective purpose (Czarniawska, 1998; Weick, 1995) by allowing managers to clarify their

interpretations of events by "stepping back from their actions" to appraise their position towards the change content and process (Rouleau, 2004: p9), as well as signalling the intentionality of their future actions (Vaara, 2002: p216).

In a discursive framework, Grant et al (2001) describe a meso-level of analysis as focusing on interpersonal and group-based interactions, while the micro-level focuses on the intrapersonal. As Beech & Johnson (2005: p33) have previously pointed out, a meso-level focus matches what is termed micro-level in the strategic literature (Johnson et al, 2003), and it is this level of analysis that is carried out within this case study.

The format of narratives can vary (Boje, 2001; Pentland, 1999), and they can be configured as a classic storyline which adopt familiar epic-heroic (Campbell, 1973) or romanticist plotlines (Jeffcutt, 1994). Alternatively, they can take the form of a pattern of themes that recur in management discourse (Dunford & Jones, 2000). The format of this study primarily takes the form of patterns of themes that emerge and recur in management discourse which are pulled together by "thematic threads" (Dunford & Jones, 2000: p1208), but it also uses a variety of figurative images which describe different actors, their actions, events, and their outcomes. The rationale for formatting the narrative in this way was to ensure that a plausible account of events, actions, and actors experiences was produced, while also engaging in the creative process which a narrative strategy requires (Brown & Jones, 1998: p40).

In many ways, sensemaking theory and narrative are relative and complimentary to each other when studying strategic change. A narrative approach focuses on how language is used to construct meaning (Barry & Elmes, 1997), which enables the disconnected elements of experience being seen as related parts of the whole through "meaning-making" (Polkinghorne, 1988: p36). Narratives act as a significant source of personal and collective sense making (Czarniawska, 1998, Dawson & Buchanan, 2005; Gabriel, 2000), and it helps researchers focus on the meaning of processes in the way that individuals experience them (Langley, 1999).

In addition to helping describe how actors give meanings to the past, cope with the present, and plan for the future (Dunford & Jones, 2000), sensemaking and narrative studies can capture the richness of the symbolic elements of strategic change that provide a more contextual view of events surrounding it in comparison to cognitive approaches (Tsoukas, 2005). Finally, adopting a narrative approach is consistent with the interpretivist epistemological position of this study (Burrell & Morgan, 1979) because it helps provide a

good understanding of how sensemaking is socially constructed through time (Hopkinson, 2001), by "unpacking the conceptual world" (Geertz, 1980: p167) that practitioners occupy.

4.2. CASE STUDY BACKGROUND

The case study involved the management of a joint strategy between two separate public sector organizations responsible for delivering addiction services in Glasgow: NHS Greater Glasgow ('NHSGG') and Glasgow City Council ('GCC'). The strategy was one that was prescribed by regulative, coercive institutional pressures from the Scottish government (DiMaggio & Powell, 1983, 1991), whom both parent organizations were accountable to.

The move towards radically changing the management of Glasgow's addiction problem was the result of political, socio-economic, and public pressures which resulted in NHSGG and GCC being charged by the Scottish Health Minister and Scottish Drugs Minister to redesign and deliver addiction services within in a joint strategy framework, as opposed to planning and delivering services separately which they had previously done.

Central to this change in direction, was the creation of Community Addiction Teams ('CATs') that included co-locating health and social workers in the same buildings to work together as joint teams. The concept of CATs emerged in response to a number of strategic initiatives and reports at national level in relation to addiction services in Scotland and the UK[14].

Three major reviews of addiction service provision were also conducted by NHSGG and GCC in Glasgow since 2001[15]. The recurring theme from these reports and reviews was that health and social work agencies needed to work more closely together, and to re-think how addiction services are jointly resourced, organized, and delivered in order to better address the complex needs of those suffering from drug and alcohol addiction.

This section summarizes the 'broad principles' of the addictions strategy and the main issues which preceded its development and implementation prior to 1st Dec.03, when CATs were officially introduced.

[14] Appendix 1 provides a detailed account of the macro -level influences upon the decision to adopt an integrated approach for addiction services and the wider institutional context in which the new addictions strategy emerged.

[15] Appendix 2 includes details these three internal service reviews, as well as other local health and social work strategies which had implications for integrating drug and alcohol addiction services.

4.2.1. The 'broad principles' of the strategy

The addictions strategy was complex, extensive, and wide-ranging. It incorporated proposals set out by the Glasgow Drug Action Team's review of addiction services in Mar.01, proposals developed by the CATs ('Community Addiction Teams') Steering Group in Apr.02, and a wide number of recommendations gained through feedback from two lengthy consultation processes that were conducted by NHSGG and GCC over a 12-month period from Apr.02-Apr.03. The strategy also included proposals from three major service reviews.

The core elements of the addiction strategy were identified through a detailed analysis of each of these documents. The researcher was also given full access to all internal documents, including meeting minutes of the Interim Joint Addiction Management Group ('IJAMG' or 'top management team') which involved those at the most senior levels of both organizations, in addition to minutes from three addiction-related cross-organizational sub-committee's whose members included middle managers from both parent organizations. The core elements of the strategy were clarified during many formal and informal discussions between the researcher and two top managers from NHSGG and GCC throughout Jun-Nov.03. These two managers had been responsible for developing the CAT Service Specification in Apr.02, which subsequently became the working template for the integrated strategy and known as 'the CAT strategy'.

The strategy consisted of three main goals:

1. Developing an 'exit strategy' for methadone service users
2. Ensuring that working in CATs is a professionally rewarding experience
3. Providing equitable and improved access to alcohol services

These three strategy goals, and the action required to support their development and implementation, are explained in more detail at the beginning of Chapters 5, 6 & 7. The strategy was promoted to members of staff at all levels of both organizations through a series of formal communication exercises which the researcher attended. Each strategy goal was clearly communicated by PowerPoint presentation, however, the details and actions required to support their implementation was not fully explicated to managers and partner agencies.

Despite many questions being put to the top management team about a wide variety of implementation issues (e.g. 'how is all this meant to happen?'), only the three broad

principles of what the strategy consisted of was known to CAT middle managers and partner agencies by the time CATs were officially introduced on 1st Dec.03. This first stage of implementing the CAT strategy involved establishing two 'pilot' CATs in the East and North East of the city.

4.2.2. The organizational context

Prior to introducing CATs, it had become apparent to the top management team that the three strategy goals were not being unilaterally embraced across the middle levels of each parent organisation. In part, this was due to the extent of the political and project management problems which had beset the strategy.

The list of problems included: a full detailed implementation plan as proposed by the Glasgow Drug Action Team in Mar.01 not materializing as planned by Jun.03, the need to hold two consultation processes as opposed to one over a 12-month period, the launch of the East and North East pilot CATs undergoing several revised introduction dates (i.e. Apr.03, Jun.03, Oct.03, Dec.03), and the ongoing public battle between two senior doctors over who should be appointed as medical director within a new joint management structure which was due to be formed over the coming months. The central theme of top management discussions had gradually shifted from structural and planning issues, towards concerns around the acceptability of the strategy, the overall likelihood of its effectiveness, and if it would succeed or not.

Issue 1: Strategy legitimacy

Top management believed that gaining organisational legitimacy (Elsbach, 1994; Meyer & Rowan, 1991; Pfeffer & Salancik, 2003) with the government regulator was unlikely to be compromised through lack of action or poor cooperation from middle managers, simply because the welfare of vulnerable groups who sought help for addiction would not be placed at risk for reasons of professional accountability.

However, feedback from communication exercises, and two organization-wide consultation processes, suggested that middle manager's acceptance of the new strategy had not yet developed. Top management was unconvinced that the strategy had gained legitimacy at micro-level. Despite attempts at fostering legitimacy via consultation and communication exercises, top management expressed doubts that the strategy had gained enough approval and acceptance from middle managers in order for it to succeed.

Issue 2: Strategy commitment

Members of the top management team expressed concerns within their meetings, and later on in private to the researcher, that middle managers "*would struggle*" with the integrated strategy, and "*have problems getting their heads round it."* Compliance and commitment on a behavioural level was less of a concern, because top management had confidence in the control mechanisms that were in place for nurses and social care workers e.g. professional codes of conduct, terms and conditions of contracts, staff appraisal systems.

Instead, the group were concerned how middle managers would reconcile themselves to an approach which top management acknowledged was a radical departure from the previous strategy, was not widely supported, and which was beginning to create division and tension across both parent organizations as the revised introduction date of 1st Dec.03 approached. Based on consultation process responses, and the types of questions being put to top management during communication exercises, middle management attitudes to the new strategy were not very positive. Top management believed that middle manager's commitment to strategic change was questionable.

4.2.3. The strategic context: adopting an umbrella strategy approach

A critical aspect of the strategy process was the acknowledgement at macro level that designing and implementing integrated addiction services was not familiar territory. Even though the Scottish Executive placed emphasis on agencies to work together towards developing integrated addiction services, its own addictions policy unit stated that little was known about the concept of integrated care for drug users. The Scottish Executive's Effective Intervention Unit's 'Guidelines for Integrated Addiction Services' were issued to NHSGG and GCC in Sep.02 and stated:

"The concept of integrated care for drug users is still relatively new… in examining the planning and delivery of care, there is a need for more evidence about the most effective approach to care coordination."

At meso level, the Glasgow Drug Action Team made a commitment in Mar.01 that NHSGG and GCC would *"develop a detailed implementation plan."* By Jun.03, top management announced that a detailed implementation plan would eventually be completed by the soon-to-be appointed Joint General Manager before the end of 2003. In a letter to managers of both organizations, the NHSGG Director of Community Planning, and GCC Depute Director of

Social Work Services, attributed planning problems and delays to the lengthy consultation processes that had taken place during 2002, by stating:

"We are persuaded that, from the balance of responses… that we should move to implement an integrated service. Our conclusion is that the best approach to this is incremental implementation, enabling many of the legitimate issues which have been raised, but can only be dealt with by moving to a practical implementation programme, to be addressed. This incremental approach would see consultation points being addressed, and be rapidly followed by the appointment of a Joint General Manager, to develop detailed implementation proposals."

"After the appointment of a Joint General Manager, the key steps will include finalizing the structure and roles of the senior management team, filling those appointments, and moving to develop detailed plans for staff migration, governance, and other operational arrangements. With regards to the central concern about the management of addiction services in the community, we propose that, as an interim step, the team leaders of Community Addiction Team [Temporary] Operations Managers should be line managed by [GCC] Area Social Work Managers, but with a strong line of accountability to the [GCC] Community Services Manager for Addiction, whose responsibilities will include operational policy and practice development. The pilot CATs will also need to link into Health line management."

The initial intention in Mar.01 was to develop a detailed implementation plan, but this did not materialise due to both parent organizations agreeing to await the outcomes of ongoing services reviews, and two lengthy consultation processes. However, were the two pilot CATs not operational before the end of 2003, funding from the 2002/2003 financial budget would be lost for the following financial year in 2003/2004, potentially resulting in CATs not being launched at all.

The "*legitimate issues*" that had been raised by middle managers during the consultation process suggested they were not fully supportive of the new strategy proposals. Top management conceded that these issues could not be resolved in the short-term. Furthermore, the new Joint General Manager, who was officially appointed in Oct.03, had very little time to develop a detailed strategic plan before 1st Dec.03. It became apparent that adopting an umbrella approach had become non-optional for both parent organizations.

It had become imperative to introduce the new addictions strategy with only "the broad outline in place, while the details would be allowed to emerged en-route" (Mintzberg & Waters, 1985: p290). Adopting the umbrella approach was not the original intention, but it was an approach which now required to be taken out of political and financial necessity. Concerns were now being expressed across all levels of both organizations about rolling out the CATs without sufficient planning, without consensus and agreement from all parties, without full operational infrastructure, and without staff resources not yet in place.

How the CAT strategy would unfold, what direction it would take, and its outcomes, were all in doubt. On the basis of the two major issues of concern outlined above (i.e. strategy legitimacy and strategy commitment), top management decided to commission a process evaluation to see what could be learned from implementing integrated services[16]. The evaluation data collection process began in Dec.03, simultaneously with the introduction of East and North East CATs.

4.3. DATA COLLECTION

Access to both parent organizations was gained by the researcher being formally appointed by the Scottish Executive, NHSGG, and GCC, to carry out the evaluation. It was anticipated by all three sponsors that the evaluation would be beneficial to the wider development of integrated addiction services in Glasgow, as well as across the rest of Scotland. The outcome of the evaluation process was to be two reports: one for the Scottish Executive's Effective Interventions Unit for national dissemination and another for NHSGG and GCC's top management[17].

Although access to strategy practitioners and internal documents was unrestricted, the 'internal researcher' role presented "risks of proximity" (Johnson et al, 2007: p67), such as the researcher becoming 'socialized' by 'going native', and becoming politically aligned with

[16] One member of the IJAMG sought research funding from the Scottish Executive, which was subsequently granted. Both parent organizations committed further funding of an equal amount to support the evaluation process.

[17] I began the doctoral programme in November 2002 and was formally appointed into the evaluation researcher role in June 2003. During the period June – November 2003, it became clear that the both organizations were undertaking major strategic change for addiction services. For this reason, I requested permission to use the data for doctoral research. A condition of contract was that I would seek publication of the evaluation findings in academic and public sector journals, and it was through this contractual agreement that I then negotiated using the data for doctoral research. Written permission was subsequently granted from all three sponsors to use the data for doctoral purposes.

one or more of the research sponsors. The researcher was based in NHSGG headquarters[18], therefore, risked becoming identified as 'a Health Board researcher.' In an attempt to mitigate these proximity risks, the researcher consciously 'dressed down' for interviews with social work managers who tended to dress more casually. However, a standard shirt and tie dress code was required when working in NHSGG headquarters, when meeting with top management, and when interviewing NHSGG middle manager participants.

Three data sources were used: document analysis, semi-structured qualitative interviews, and observation at committee meetings, communication exercises and training events. A document analysis was conducted between Jun-Nov.03, consisting of both internal documents (meeting minutes), and external documents (national drug and alcohol treatment strategies, wider social work and health agendas). This enabled a chronology of events to be established before implementation commenced and to provide historical and contextual data (Denis et al, 2001; Langley, 1999).

As previously highlighted in Chapter 2 (Section 2.3), the research agenda was set with - and by - managers of both parent organizations (Balogun et al, 2003: p201). The content of semi-structured interviews was designed around the three strategy goals, and the actions which were required to support their execution. In addition, the interviews focused on the activities, discourses, interpretations and experiences of middle managers in relation to the two issues of concern which top management has been discussing (i.e. strategy legitimacy and strategy commitment). The content of the interview schedules were agreed with top management, and piloted successfully with four managers from both organizations. Some adjustments were made with regards to questions which were more appropriate and relevant to CAT managers than partner agency managers, and vice versa.

A total of 105 semi-structured in-depth interviews took place from December.03 to December.04 involving 35 middle managers: 16 frontline managers and 19 partner agency managers. All participants gave written consent to their participation, and each retained a

[18] During the latter stages of the evaluation, I became aware that NHSGG and GCC top management had been in disagreement about where I should be based. My interpretation of this issue was that both organizations wanted greater ownership and control of the evaluation process, as well as more frequent contact with me to gauge the feedback I was receiving from participants. It also had implications for which secretaries were transcribing the interviews. NHSGG were particularly concerned about GCC administrative staff being privy to the content of NHSGG member's views from the interview tapes.

signed copy of the consent form agreement[19]. Interviews took place over three separate time periods, and each interview lasted from 45-120 minutes.

The researcher was granted access to a number of addiction-related cross-organizational sub-committee meetings, solely to observe and listen to discussions. Three communication exercises were staged prior to Dec.03, and the researcher took notes of the questions and concerns highlighted by CAT and partner agency middle managers. Joint training events were held through the course of the evaluation period which the researcher attended.

Table 4.3.1 Data collection schedule

Time	Dates	Stage implementation	Interviews
T1	Dec.03	Implementation begins	35
T2	May.04	6 months into implementation	35
T3	Dec.04	12 months into implementation	35
			Total = 105

Sampling strategy

Middle managers were initially selected on the basis of their geographical location. The East and North East (NE) of Glasgow had been identified as the most socially deprived areas of the city. They had a significantly higher incidence of drug and alcohol abuse in comparison to other parts of Glasgow. NHSGG and GCC decided that these two areas should be considered a strategic priority. Although nine CATs in total were planned to be established across the city, the East and NE CATs would be rolled-out before all others, and therefore chosen by top management to act as 'pilot teams' for the purposes of evaluation. One top manager commented to the researcher that, *"if CATs work in the East and North East, then they would work anywhere else."*

35 middle managers from the East and NE localities were identified as potential 'strategists' (Jarzabkowski et al, 2007). Mantere (2007) has pointed out that the most common expectation of middle managers in a strategic context is the expectation to implement strategy

[19] The research design and methodology required to pass a stringent review process by NHSGG's Research Directorate. A standard NHSGG participant consent form was required to be signed by all participants. The researcher agreed with GCC top management that the consent form should be adapted by adding the corporate logo of GCC alongside that of NHSGG for symbolic purposes to ensure the study was not viewed as a 'NHS' study by GCC participants.

(p8). In an umbrella strategic context, it was these 35 managers who would be directly involved in developing and implementing the CAT strategy en route.

According to Thomas & Linstead (2002), middle managers are generally portrayed as a single, univocal, and homogenous entity. However, these middle managers were not a single homogenous group because (1) they belonged to different parent organizations (NHSGG or GCC), (2) they were members of different organizational sub-groups that provided drug and alcohol services including Glasgow Drug Problem Service (NHSGG), the GP Shared Care Scheme (NHSGG), the Alcohol & Drug Directorate (NHSGG), and East and NE Addiction Teams (GCC), and (3) they came from different professional backgrounds (e.g. some were doctors and nurses, while others were social work services managers).

Therefore, a non-random purposive sampling strategy was employed to ensure the sample was representative of all those managers most affected by the change (Patton, 2002). Sample selection criteria were based on ensuring that managerial involvement of those from the 'pre-integration' structure was evenly represented. Two groups of middle managers were identified: CAT managers, and 'partner agency' managers. CAT managers were selected on the basis of their seniority, the scope of their managerial responsibility for service delivery, their active participation in integrated service development groups, and the extent of their supervisory responsibilities for lower-level employees.

Partner agency managers were selected on the basis that they would continue to be directly involved in addiction service provision (e.g. GPs who prescribed methadone[20] and social work managers from Criminal Justice services etc). The demographics of each managerial group are detailed in Table 4.3.2 which illustrate their professional backgrounds, parent organizations, sub-group affiliations, and the client groups they provided for.

The sample offers equal weighting of health and social work managers from both CATs, which provides the potential for group and team comparisons (Patton, 2002). Partner agency managers from 'community health services' are intentionally over-represented as they were considered by top management to be critical to the success of the CAT strategy[21].

[20] Six GPs who were known to refuse to prescribe methadone, and who were not involved in the GP Shared Care Scheme, were invited to participate in the evaluation. None responded to invitation by letter or telephone.
[21] Community Health managers were 'Lead GPs' who represented large groups of GPs in each of the main health centres in the East and NE localities. Although only three community social work managers were selected, two of these managers managed both Children & Families and Criminal Justice services, and therefore, were able to offer a perspective around how CATs were working with both of these agencies.

Table 4.3.2 Demographics of CAT managers

No.	Agency	Profession	Organization	Sub-group	Client group
1	East CAT	Social work	GCC	East Addictions Team	Stable drug users
2	East CAT	Social work	GCC	East Addictions Team	Stable drug user
3	East CAT	Social work	GCC	East Addictions Team	Stable drug users
4	East CAT	Social work	GCC	East Addictions Team	Stable drug users
5	East CAT	Health	NHSGG	A&DD	Alcohol dependency
6	East CAT	Health	NHSGG	A&DD	Alcohol dependency
7	East CAT	Health	NHSGG	GDPS	Chaotic drug users
8	East CAT	Health	NHSGG	GDPS	Chaotic drug users
9	NE CAT	Social work	GCC	NE Addictions Team	Stable drug users
10	NE CAT	Social work	GCC	NE Addictions Team	Stable drug users
11	NE CAT	Social work	GCC	NE Addictions Team	Stable drug users
12	NE CAT	Social work	GCC	NE Addictions Team	Stable drug users
13	NE CAT	Health	NHSGG	GDPS	Chaotic drug users
14	NE CAT	Health	NHSGG	GDPS	Chaotic drug users
15	NE CAT	Health	NHSGG	A&DD	Alcohol dependency
16	NE CAT	Health	NHSGG	A&DD	Alcohol dependency

Table 4.3.3 Demographics of partner agency managers

No.	Agency	Profession	Organization	Subgroup	Client group
17	Community	GP / Medical	NHSGG	GDPS[22]	Chaotic drug users
18	Community	GP / Medical	NHSGG	GP Shared Care	Stable drug users / Alcohol
19	Community	GP / Medical	NHSGG	GP Shared Care	Stable drug users / Alcohol
20	Community	GP / Medical	NHSGG	GP Shared Care	Stable drug users / Alcohol
21	Community	GP Manager	NHSGG	GP Shared Care	Stable drug users / Alcohol
22	Community	GP Manager	NHSGG	GP Shared Care	Stable drug users / Alcohol
23	Community	GP Manager	NHSGG	GP Shared Care	Stable drug users / Alcohol
24	Community	Pharmacy	NHSGG	GP Shared Care	Chaotic & stable drug users
25	Community	Nurse	NHSGG	Mental Health	Severe mental illness
26	Specialist	Medical	NHSGG	Obstetrics	Pregnant mothers (drugs)
27	Specialist	Social work	GCC	Children& Families Criminal Justice	Chaotic & stable drug users
28	Specialist	Social work	GCC	Children& Families Criminal Justice	Chaotic & stable drug users
29	Specialist	Social work	GCC	Drug Court	Chaotic drug users /alcohol
30	Specialist	Nurse	GCC / NHSGG	Homelessness	Chaotic drug users
31	Specialist	Social work	GCC / NHSGG	Crisis Centre	Chaotic drug users
32	Specialist	Voluntary	GCC / NHSGG	Council for Alcohol	Alcohol dependency
33	Hospital	Psychiatrist	NHSGG	A&DD	Alcohol dependency
34	Hospital	Nurse	NHSGG	A&DD	Alcohol dependency
35	Hospital	Psychologist	NHSGG	Psychology	Alcohol dependency

[22] At T3, this participant ('Dr. Jane') was replaced by another ('Dr. Robert') from the GDPS, as the former had resigned following the T2 interview.

Table 4.3.4 Quantitative summary of middle managers interviewed

	CAT managers n = 16	Partner agency managers n = 19
East CAT SW	4	
East CAT Health	4	
NE CAT SW	4	
NE CAT Health	4	
Community Health services		9
Specialist Services		7
Hospital Health services		3

4.4. DATA ANALYSIS PROCESS

All interviews were tape-recorded and transcribed. All transcriptions were analysed using NVivo 8, a text software analysis programme[23]. The analytical process involved several stages. Transcripts were coded into two managerial categories (i.e. CAT managers and partner agency managers), and then into five managerial sub-group categories:

CAT Managers	Partner agencies
(1) Vertically co-opted	(3) Community Health managers
(2) Horizontally co-opted	(4) Specialist Services managers
	(5) Hospital Health managers

'Vertically co-opted' CAT managers were directly co-opted into top management level discussions around developing the addictions strategy, while 'horizontally co-opted' CAT managers were not co-opted upwards, but given the responsibility for developing the finer details strategy goals at local [team] level.

Data was initially formed into individual narratives of each actor's accounts of the strategy process. Individual narratives were then aggregated, and a narrative for each managerial sub-group was then produced in order to form a 'thick description' (Lincoln & Guba, 1985) of events in relation to individual strategy goals over each of the three time periods: Time 1 (T1), Time 2 (T2), and Time 3 (T3).

Data was then coded in relation to each of the three strategy goals as participants referred to them: developing an 'exit strategy' for methadone service users (Goal 1), ensuring that working in a CAT was a professionally rewarding experience (Goal 2), and providing equitable and improved access to alcohol services (Goal 3). This process required some degree of data reduction from the 105 scripts that were initially produced, but retained the contextual detail of each individual narrative to ensure that divergence and 'voices of difference' were still represented in the broader group narratives (Beech & Johnson, 2005; Czarniawskia, 1997; Langley, 1999).

[23] Due to major IT problems, only the first-order analysis was carried out using NVivo 8. Second and third-order analysis was carried out manually.

A first-order analysis (Gioia & Chittipeddi, 1991; Van Maanen, 1979) was carried out to establish the dominant themes from each narrative. This focused on "the situational, historical, and biographically mediated interpretations" (Van Maanen, 1979: p540) of each managerial group with regards to each strategy goal, and the associated actions required to support their development and implementation. Each group narrative was examined for evidence of acceptance, approval, and adoption of the strategy goals, and data that suggested otherwise (Barry & Elmes, 1997). Narratives were coded as 'accepting,' 'approving,' and 'adopting,' or 'un-accepting,' 'disapproving,' and 'non-adopting'. When actor's expressed elements of acceptance and non-acceptance in relation to specific strategy goals, data was coded as 'ambivalence' (Piderit, 2000).

A second-order analysis was carried out to address research Q1. This involved searching for 'evaluative statements' within the above first-order categories to explore if these actor's positions were based on evaluations of each strategy goals' legitimacy, and if they were behaviourally and attitudinally committed or not to the development and implementation of these goals.

This level of analysis draws upon two techniques from Fairclough's (2003) discourse analysis framework: evaluation and modality[24]. Fairclough (2003: p164) proposes that evaluation and modality are critical in discursive terms as they signal what actors find desirable or undesirable, what is good and what is bad ('evaluation'), and what they commit to, with respect to what is true and what is necessary ('modality'). Therefore, I began analyzing each narrative by focusing on their evaluative content and modality.

Evaluative statements from each narrative was analysed to examine actor's appraisals of strategy legitimacy[25]. Evaluative statements can be both explicit and implicit (Fairclough, 2003: p172), and state what is perceived to be good or bad, or right or wrong etc. Evaluative statements are indicative of participant's sensemaking activity (Weick, 1995) when they include, or begin with, a clause with a 'mental process' verb such as 'I think' or 'I believe' (Fairclough, 2003: p109).

Evaluative statements were coded as 'positive,' or 'negative.' Positive evaluations of legitimacy were coded as 'high level legitimacy', and negative evaluations were coded as

[24] The philosophical basis of Fairclough's (2003) critical discourse perspective is not drawn upon. These two techniques are used for analysis purposes only.
[25] The data that was selected and coded at this stage was determined by what legitimacy or commitment-type was predominantly expressed in each group narrative.

'low level legitimacy'. The *basis* of each actor's evaluation was then examined to determine what form of legitimacy was either explicit or implicit within their statement i.e. pragmatic, moral, or cognitive, including their variants (Suchman, 1995). Three illustrative examples are provided below:

Goal	Evaluative statement	Content	Level of legitimacy	Basis of legitimacy
1	'Things work fine for my department. I believe there's no reason to change things'	Negative	Low	Pragmatic *(exchange)*
	'I think we should change the service to help the clients'	Positive	High	Moral *(consequential)*
	'The system is so complicated. I can't work out how all the pieces fit together'	Negative	Low	Cognitive *(comprehensibility)*

Modality issues are concerned with commitments, attitudes, judgements, and stances, but also with action and social relations (Fairclough, 2003: p166). Fairclough (2003) classifies two types of modality which can be associated with different forms of social exchange: knowledge exchange ('epistemic' modality) and activity exchange ('deontic modality'). This data analysis process draws primarily on activity exchange because its speech function is associated with actions and attitudes. Fairclough (2003) presents two types of activity exchange: '[to] demand' and '[to] offer'. This case studies' analysis was particularly concerned with the speech act [to] 'offer' – which includes making promises, making threats, and generally indicating one's intent through language (Fairclough, 2003: p108).

Table 4.4.1 Fairclough's (2003) example of activity exchange ('deontic modality')

Offer:	the 'author's' commitment to act
Undertaking:	I <u>will</u> open the window
Modalize:	I <u>may</u> open the window
Refusal:	I <u>won't</u> open the window

This modality was chosen to analyse actors discourse in relation to the concept of strategy commitment, as it provided a mechanism to analyse actor's attitudes towards change, and their commitment to act in ways which supported (or not) the development and implementation of strategy goals. Modalities that described manager's attitudes and behaviours which were consistent with the broad principles of each strategy goal were

initially identified (e.g. managers should work towards moving clients towards full rehabilitation), and these were coded as 'high' or 'low' strategy behavioural commitment. Similarly, modalities which reflected managerial attitudes towards change were coded as 'high' or 'low' strategy attitudinal commitment if they were congruent with the espoused view, or else contrary to it. Four illustrative examples are provided below:

Goal	Narrative theme	Type of strategy commitment	Level
2	'It will be a good thing for us to be more skilled and have more time to help the clients'	Behavioural	High
	'I don't see the point in trying to change things. We won't ever achieve what we are supposed to'	Behavioural	Low
	'I'm hopeful the new approach will work. It's about time we do things better than before'	Attitudinal	High
	'There's no way the strategy will work. We all work in completely different ways when it comes to addiction'	Attitudinal	Low

After establishing what form of level legitimacy and commitment were at play, the nature of the legitimacy-commitment relationship for each strategy goal was then analyzed. Narratives from T1, T2, and T3 were selected that related to each strategy goal, to establish if the strategy legitimacy-commitment relationship was reciprocal, non-reciprocal, or both.

A third-order analysis was carried out to address research questions 2a, 2b, and 3. This level of analysis 'drilled down' further, and focused specifically on the contextual factors associated with umbrella strategies that influenced actor's legitimacy-commitment evaluations and practices. This stage involved conducting a content analysis of group narratives (Miles & Huberman, 1994), which set out to identify if umbrella conditions influenced strategist's evaluations and their subsequent practices en route.

For example, umbrella issues relating to clarity of direction, partial control, clarity of roles, ambiguity over boundaries, issues around autonomy and discretion, co-optation, participation, and the extent that all of these factors had on developing the finer details of the strategy en route. Those umbrella conditions that provided justifications, rationales, and explanations for what managers describe they are doing as they developed the finer details of the strategy were of particular interest.

A key objective for strategy-as-practice researchers is to explore what practices are consequential for firm outcomes (Johnson et al, 2007). Therefore, those middle manager practices, which could be related to umbrella conditions, were then examined in terms of how consequential they were for firm outcomes (Jarzabkowski et al, 2007).

4.4.2 Structure of the data findings

Chapters 5, 6, and 7 include data findings that present a first, second, and third-order analysis of each strategy goal from three data collection periods over twelve months: T1 (implementation begins at December.03), T2 (mid-implementation at May.04), and T3 (post-implementation at December.04).

These chapters include analysis points at the end of each second and third-order analysis sections, in order to briefly highlight the nature of individual strategy legitimacy-commitment relationships as they emerge in the data findings i.e. reciprocal, non-reciprocal, or both. All of these individual analysis points are collectively illustrated in Chapter 8 (see Table 8.1 and Table 8.2).

Chapter 8 also discusses and analyzes [third-order] data findings relating to Q2a, Q2b, and Q3.

Table 4.4.2 Structure of analysis chapters

	Goal		Time	Date
Chapter 5	1	Develop an 'exit strategy' for methadone service users	T1	Dec.03
			T2	May.04
			T3	Dec.04
Chapter 6	2	Ensure that working in CATs is a professionally rewarding experience	T1	Dec.03
			T2	May.04
			T3	Dec.04
Chapter 7	3	Provide equitable and improved access to alcohol services	T1	Dec.03
			T2	May.04
			T3	Dec.04

CHAPTER 5 DATA FINDINGS

Strategy Goal 1: Develop an 'exit strategy' for methadone service users

> *"We will ensure that an integrated service pathway includes a systematic approach to care. Methadone must be more widely available to those entering the service, but we also must better manage the increasingly high numbers of those seeking methadone treatment. This includes developing an exit strategy for service user's to enable them to move forward towards full rehabilitation."* **(Glasgow Addictions Strategy, Jun.03)**

TIME 1 (December 2003)

FIRST-ORDER ANALYSIS

'Bottlenecks and desperate cases'

In response to Glasgow's increasing heroin problem in the 1990's[26], NHSGG created two community-based methadone services: the Glasgow Drug Problem Service ('the GDPS')[27] and the GP Shared Care Scheme ('Shared Care')[28]. These two services held distinct functions and operated quite differently.

The GDPS provided medical treatment and methadone to those with severe opiate addiction who were too unwell, chaotic, and problematic for their own GPs to manage. Referrals were only accepted into the GDPS from GPs. The GDPS was a strictly medical-orientated service with no social work input.

[26] In 1999, there were 69 drug-related deaths in Glasgow with 1900 patients seeking help for heroin addiction. This compared to Lothian region which had 7 drug-related deaths and 530 new patients seeking help. By 2000, Glasgow's methadone programme was unfit for purpose because of the increasing numbers of patients being treated rising to 3700. NHS Greater Glasgow and Glasgow City Council estimated there were around 15,000 heroin injectors in the city.

[27] GDPS provided methadone therapy at four health centres across the North, South, East, and West of the city. These clinics were run by several doctors who were specifically contracted to provided medical treatment and prescribe methadone. GDPS clinics were supported by Registered General Nurses ('RGNs') whose key responsibilities included dressing ulcerated wounds caused by injecting heroin, taking urine tests to monitor abstinence, and taking blood to test for Hepatitis B & C, and HIV.

[28] As 'prescribing GPs' tended to provide methadone to many of their patients in the East and NE localities, they elected to hold weekly methadone clinics at their GP surgeries rather than to see each patient individually. This was found to be more efficient and less troublesome for their other patients who were uncomfortable sharing waiting rooms with known IV drug users.

The Shared Care Scheme was run by GPs who were contracted by NHSGG to prescribe methadone. Shared Care clinics supported those clients who had been stabilized by GDPS, but who would continue to require ongoing longer-term methadone therapy from their own GPs. In contrast to GDPS clinics, Shared Care clinics involved social workers who worked alongside GPs if clients required support for housing, legal, employment, or financial issues.

Capacity management issues had come to dominate the way in which the GDPS and Shared Care Scheme were functioning[29]. Methadone clinics were often full to capacity, leading them to be *"under severe pressure"* and resulting in *"bottlenecks."* GDPS had begun to operate on the basis that they only accepted referrals of *"the most desperate cases."*

Shared Care GPs were "*toiling,"* as they had discovered that the consequence of being recognized as a 'prescribing practice' was that more patients attempted to enlist at their surgeries for methadone therapy. This meant that they faced *"the constant threat of being snowed under."* Shared Care GPs no longer referred any new cases to GDPS because they would eventually be obliged to accept these patients back into their Shared Care clinics once they had been stabilized by GDPS. This had become impossible to do because there were no more spaces available within Shared Care clinics.

"If a GP won't prescribe methadone for the patient, or won't refer them on to us at GDPS or someone else who will, it means patients are denied treatment. So there is a realization that there are people out there who are really desperate." (Dr. Jane, GDPS, Community Health)

It was envisaged by top management that the introduction of well-resourced CATs would help alleviate the current capacity management problems with the methadone programme. But any hope of progress on this issue at Time 1 was premature, as the participation of GPs in helping develop an exit strategy for methadone service users was suddenly cast into doubt.

'Miscalculations and negotiations'

During summer 2003, the British Medical Association ('the BMA') agreed a new contract for GPs with the UK government[30]. A condition of the new GP contract involved an increase in

[29] As CATs were being introduced in 2003, 5500 clients in Glasgow were prescribed methadone. Over 650 of this group were 'unstable' and managed by GDPS, while less than 5000 were 'stable' and managed by Shared Care.

[30] The General Medical Services Contract, or 'GP contract,' was created to improve recruitment and retention of GPs, reward quality of care, allow GPs more influence in the development of community services beyond General Practice, and to reduce contract bureaucracy.

the level of payment GPs would receive for providing 'enhanced services'[31]. Methadone prescribing was one such enhanced service that was contracted based on national benchmark prices. GPs had previously been paid £150 per year for each patient they provided methadone therapy to. However, the BMA had negotiated a substantial increase to £350 per patient. NHSGG, who contracted GPs to provide this enhanced service, had not budgeted for a £200 cost increase for each patient in Glasgow who received methadone via the Shared Care Scheme.

By Nov. 03, NHSGG executives began formal negotiations with the BMA's Local Medical Committee who represented Glasgow GPs. Agreement on enhanced services payments could not be reached, but Glasgow's GPs were uncompromising in their position and would not accept a figure that was less than what the BMA had originally negotiated at national level earlier that year. Eventually, NHSGG reluctantly offered the nationally agreed fee of £350 per patient for one year up until 1st Apr.05, with the condition that further ongoing negotiations would take place during 2004 to discuss contract payments beyond 1st Apr.05.

"The GP contract is a national contract, so we thought, 'well, it is a national contract and we will be getting national rates'. But the Health Board has now said, 'well, we can't afford it.' So, there have been some quite acrimonious discussions going on, which is the best way to put it. The short-term measure is that they will fund us for one year only for now."

(Dr. Paul, GP, Community Health)

The future funding of the methadone programme had serious implications for the integrated strategy. Without GPs participation, an exit strategy would be difficult to implement, if not unworkable. The GP contract issue exacerbated an already longstanding problem in Glasgow. Many of Glasgow's GPs had simply refused to prescribe methadone on ethical, moral, and efficacy grounds. The contract problem reduced the prospect of persuading more GPs to prescribe methadone, so as to increase capacity within the Shared Care Scheme.

The GP community were reported to be extremely dissatisfied that the enhanced services payment issue had not been fully resolved. At Time 1, GPs were **ambivalent** about contributing to the development and implementation of the methadone service's exit strategy.

[31] Four types of services are provided by GPs to Health Boards. These include: essential services (general management of patients); additional services (cervical screening, contraceptive services, child vaccinations and immunisations, maternity services and minor surgery); enhanced services (services commissioned by Health Boards or Primary Care Organizations with a guaranteed funding floor that model national specifications and benchmark prices); and Out-Of-Hours services.

'If you go into the methadone programme, you never come back out'

The implications of the GP contract raised concerns from those managers whose Specialist Services performed a 'stabilizing function' for complex addiction-related cases. These managers relied heavily on Shared Care GPs agreeing to continue prescribing methadone as a means of moving clients out of Specialist Services.

For example, clients in the Homelessness Addiction Team ('the HAT') who had found a tenancy could not be transferred into Shared Care clinics because these clinics were full. Likewise, clients at the Drugs Crisis Centre could not be moved on if no GP could be found to prescribe methadone for them in the long term. This problem restricted these services' capacity to admit new 'homeless' or 'crisis cases' because *"the clients who were already there had nowhere to go."*

Specialist Service managers were highly **approving** of the concept of transferring clients out of their own services and on to CATs, who would then be responsible for moving them onwards to full rehabilitation. The cumulative effect of existing problems meant that clients not only experienced difficulty getting onto the methadone programme, but they subsequently had problems getting off it as there was no exit strategy in place.

"It is critical that we develop an exit strategy for those on methadone, so that the whole system can begin to function properly." (John, HAT, Specialist Service)

SECOND-ORDER ANALYSIS

First-order analysis highlights some variance between Community Health and Specialist Service managers' level of support towards developing and implementing Goal 1. Time 1 narratives are now analyzed further to examine how levels of acceptance, approval, and adoption were influenced by middle manager's legitimacy and commitment evaluations, and whether the relationship between these evaluations were reciprocal or non-reciprocal.

Example 1: Community Health managers

Community Health managers conferred **high moral legitimacy** upon Goal 1, in its variant form of *consequential* legitimacy. They offered unanimous support to the broad concept of moving people on towards full rehabilitation. Retaining patients on methadone indefinitely was *"the wrong answer for everyone involved."* As a 'substitute therapy', GPs believed that

methadone treatment *"only offered a crutch, not a cure,"* and that that their patients *"were entitled to a normal life without methadone and heroin."*

Community Health managers also conferred **low pragmatic legitimacy** upon Goal 1, in its variant form of *exchange legitimacy*. Following the unsuccessful negotiation of the GP contract, this group of managers had become disinclined to help resolve system throughput problems. GPs were unhappy that they had no assurances from NHSGG that they would be fully compensated in the long-term in exchange for their role as methadone prescribers. They argued that if their contribution to the success of an integrated service was so critical, then NHSGG should accept the terms of the GP contract accordingly.

NHSGG executives were seen to have failed in their obligation to accept the terms of the GP contract. GPs pointed out that they had found themselves having to negotiate for what was already the nationally-agreed benchmark price of £350 for enhanced services. Even then, they argued, NHSGG executives seemed reluctant to agree to the benchmark price up until April 2005. GPs believed that they were being coerced into a position to shoulder the burden of increasing numbers on the methadone programme at no extra cost.

"We do get demoralised at times because of the workload. Yet, we are being put under more and more pressure to maintain the methadone service and to take on additional patients. That is where the difficulty is." (Dr. Richard, GP, Community Health)

While the BMA's Local Medical Committee were seeking assurances about GPs longer-term involvement in the integrated addiction service, stories began circulating that top management had begun secretly discussing *"alternative prescribing arrangements"* that potentially excluded the input of Glasgow's Shared Care GPs. Community Health managers subsequently expressed **low attitudinal commitment** towards Goal 1.

"It is being suggested that there is the potential to take things away from the GPs. My GPs are not too happy about the whole thing. So, we are just holding fire at the moment. I don't think all of this is helping matters where the CATs are concerned." (Bill, Community Health)

<u>Second-order analysis point</u>

At Time 1, Community Health managers' narratives suggested that the legitimacy-commitment ('L-C') relationship was both reciprocal and non-reciprocal.

On one level, it was reciprocal. For example:

(1: CH[32]) Low pragmatic *(exchange)* legitimacy coexisted with low attitudinal commitment.

On another level, the L-C relationship was non-reciprocal. For example:

(2: CH) High moral *(consequential)* legitimacy coexisted with low attitudinal commitment

Example 2: Specialist Service managers

Specialist Service manager's conferred **high pragmatic legitimacy** upon Goal 1, in its variant form of *exchange legitimacy*, in addition to demonstrating **high behavioural commitment**. This group of managers lauded top management's proposal that CATs would facilitate an exit strategy for clients, as it would be of particular benefit to the operation of their own services. They believed CATs would be better able to assist the throughput of stable cases from the HAT, the Drug Court, the Drugs Crisis Centre, and the Women's Reproductive Health Service.

These managers anticipated that they would be able to transfer complex cases that were no longer 'chaotic,' back into CATs, and this would free up places in their own services'. They saw CATs as being able to fulfil some of the responsibilities currently undertaken by Specialist Services, and this would help alleviate their own workloads.

"The East End is just horrendous. Absolutely horrendous with poverty, addiction, domestic violence, child abuse...the whole thing is just one big complete mess. With Children & Families and Criminal Justice services, we are awash with far too many referrals to cope with by ourselves, so we need to 'prioritize the priorities' if you like, and think about how we can use the CATs to help us deal with this mess."

(Linda, Children & Families / Criminal Justice, Specialist Service)

"We see part of our own exit strategy – if you want to call it that – as through the CATs. The CATs are now on our pathway to stabilize people and get them back into mainstream or non-specialist services. It will help us identify those people we should be keeping in the HAT, and those who we can aggressively transfer into CATs. So, it should increase the flow of people through the service." (John, HAT, Specialist Service)

[32] Each analysis point is coded for reference purposes. All individual analysis points are collectively illustrated in Chapter 8 (see Table 8.1 and Table 8.2).

Second-order analysis point

At Time 1, Specialist Service managers' narratives suggested that the L-C relationship was reciprocal. For example:

(3: SS) High pragmatic *(exchange)* legitimacy coexisted with high behavioural commitment.

THIRD-ORDER ANALYSIS

The reasoning which underpinned middle manager's legitimacy and commitment evaluations of Goal 1 is now examined on a third-level of analysis. It explores how their evaluations were shaped by umbrella context factors i.e. clarity of direction, partial control, clarity of roles, ambiguity over boundaries, issues around autonomy and discretion, co-optation, participation, and the extent that all of these factors had on developing the finer details of the strategy en route[33].

Sub-group: Community Health managers

'We seem to be leaping into the unknown'

Community Health managers conferred **low cognitive legitimacy** upon Goal 1, in its variant form of *poor comprehensibility*. They described not having enough detailed information to be able to comprehend how capacity management issues could be resolved simply by creating an integrated service.

Top management had yet to make it clear what the future held for GDPS and the Shared Care Scheme within the new integrated structure, and GPs were *"still not 100% sure where everything fell into place."* They were mystified how an exit strategy could be implemented via the rumoured 'alternative methadone model,' when Community Health managers were not participating in the model design process. Were GPs were not central to the exit strategy process, then it seemed implausible to them as to how Goal 1 could ever succeed.

"I don't know how the methadone service is going to look a year from now. I mean, we have not been told directly if there is going to be a change to how the methadone service is to be provided." (Dr. Richard, GP, Community Health)

[33] Chapter 8 discusses and elaborates further upon how umbrella context factors appeared to influence strategists' practices en route.

This group believed that there appeared to be too much emphasis on emergent strategizing en route, as opposed to deliberate directives being explicitly communicated to them at the outset about how best to proceed with managing capacity and developing Goal 1.

"We seem to be leaping into the unknown really. We just don't know how the open door policy is going to work, and what the level of unmet need is. We have opened up the referral pathways via CATs, so I imagine the numbers will increase. It would be a major problem if the CATs have to deal with everybody by assessing them and then they can't find a prescriber or a pharmacy placement for the prescription to be dispensed."

(Carol, Pharmacist, Community Health)

In the early stages of the implementation process, Community Health managers reported that the emergent activities of other middle managers were not being formally communicated to them. They conceded that although strategic activity may be ongoing and taking place elsewhere, they had little way of knowing how Goal 1 was being developed en route by other strategists. To better gauge the progression of the exit strategy beyond anecdotal evidence, they proposed that top management and CAT managers needed to be more forthcoming about ongoing developments. How they planned to work with partner agencies required putting in place some formal feedback mechanisms to inform them of the ongoing progress of Goal 1.

"The CAT managers probably know in their own heads what it is they want to do, but they need to be clear and let us know what is going on." (Dr. Paul, GP, Community Health)

Community Health managers also conferred **low moral legitimacy** upon Goal 1, in its variant form of *procedural legitimacy*. They questioned the robustness of the strategy-making process by asking how middle manager strategists could determine how their activities were going to be effective if no performance framework beyond 'the broad principles' of Goal 1 had not been formulated. These managers were unsure how they might be able to discriminate en route between what was deliberate and intended, versus ongoing emergent activity that had not been planned.

"I don't think we've got a consistent quality indicator or framework of what the integrated service should look like and how the [methadone] programme should work. I.e. if you are providing methadone, this is the all things you should do etc. Some of these issues will start to come up as nobody seems to have thought them through." (Lorna, Community Health)

Community Health managers asked the question that if no performance framework was in place against which to measure what other strategists were doing, then how were they to know if their own emergent activity was consistent with the aims of other strategists.

"I am not quite sure what their success is based on. I guess they're not quite sure either. I mean, how you can measure something if you don't really know what the indicators are at the beginning, or where you want to get to?" (Dr. Gerry, GP, Community Health)

Third-order analysis point

Community Health manager's third-order evaluations did not change the nature of the L-C relationship, as it remained reciprocal. For example:

(4: CH) Low cognitive *(comprehensibility)* legitimacy coexisted with low attitudinal commitment.

(5: CH) Low moral *(procedural)* legitimacy coexisted with low attitudinal commitment

Sub-group: Specialist Service managers

'Interpreting edicts as justification for passing the buck'

In contrast to their Community Health colleagues, Specialist Service managers conferred **high cognitive legitimacy** to Goal 1, in its variant form of *high comprehensibility*. They had begun to carefully analyze the implications of the CAT strategy document, and immediately identified *"opportunities"* for their own services. Under the old service structure, the HAT, the Drugs Crisis Centre, and the Drug Court, had effectively become *"holding services,"* partly because they each had an 'on-site' methadone prescriber.

GPs in Shared Care had long argued that clients should remain with Specialist Services as they already had a methadone prescriber, and because they themselves could not take any more clients into their clinics. However, from the perspective of Specialist Service managers, the edict from the CAT strategy document to create an exit strategy was interpreted in a literal sense, and as *"a green light"* to move their clients on into CATs. They contended that the old arguments from GPs could no longer prevail or be upheld.

Specialist Service managers brazenly described how they planned to best exploit these opportunities for their own benefit. Despite offering only a passing concern about the impact

of suddenly transferring many of their clients into CATs, they were still prepared to do so. They had identified that CATs were not prepared enough to manage their incoming referrals in an *"organized fashion,"* and therefore, this was the time to shift many of their clients across into CATs *"even though the medical support didn't appear to be there."* This area was one of the *"holes"* in the strategy that they intended to exploit early on in the implementation process.

For example, the Drug Court manager explained how CATs could be more involved in managing clients placed on Drug Treatment & Testing Orders ('DTTO's) which lasted from anywhere between from 6 months to 3 years.

"The DTTO's offer the courts another form of disposal that involves probation plus conditions instead of jail. But now, we can see that there is an opportunity to refer someone on to CATs as they will have access to prescribing services. It gives us the option to transfer people on, as their compliance can still be monitored by the CATs."

(Maria, Drug Court, Specialist Service)

The HAT manager also expected changes to existing arrangements between his own service and the GPs, even though these could have consequences for CATs. He believed that the deliberate element of Goal 1 permitted him to *"aggressively transfer"* clients into CATs and that he was perfectly justified in his intent to do so.

"This strategy allows us to say to the CATs, 'this individual is no longer homeless. They have a tenancy in your catchment area and they are stabilized on methadone, so we are passing them over to you'. It allows us then to have more movement for those patients who are coming in through the HAT and back out the other end. This is a gap that the CAT can fill for us by loosening the bottleneck in our own service." (John, HAT, Specialist Service)

<u>Third-order analysis point</u>

Specialist Service manager's third-order evaluations did not change the nature of the L-C relationship, as it remained reciprocal. For example:

(6: SS) High cognitive *(comprehensibility)* legitimacy coexisted with high behavioural commitment.

TIME 2 (May.04)

FIRST ORDER ANALYIS

'Trying to solve old problems, but starting a new crisis'

By Time 2, the GP contract issue was cited by all CAT and partner agency managers as having *"a hugely enormous impact"* on the development of the exit strategy. NHSGG had failed to meet the GPs demands to be paid the nationally-agreed enhanced services fee of £350 for each patient to whom they prescribed methadone.

Top management subsequently decided to take a number of radical steps which held major implications for Glasgow's two community-based methadone services, the future delivery of the methadone programme, and CATs ability to implement an exit strategy. These steps were emergent and not deliberately-planned prior to Time 1.

In Apr.04, the development of an *"alternative methadone model,"* which Shared Care GPs suspected that top management were secretly designing, was now being made public. The new 'CAT clinic model' would effectively lead to the dismantling of the GDPS, whose doctors were notified by letter in early Apr.04 that "*their services would no longer be required."* Those GPs involved in Shared Care had *"a stay of execution"* until 1st Apr.05, when the temporary enhanced services agreement with NHSGG would expire.

It was decided that the now former GDPS would function as a 'bridge agency' in the interim, mainly to support the transfer of 400 patients (who had previously received their methadone scripts and medical support from the GDPS) into the new East and NE CAT clinics. It was intended that the CAT clinics would fulfil the same role as the former GDPS clinics had done. Namely, to manage those clients who were too unstable or chaotic for their own GPs to cope with, as well as those who didn't have a GP because they had been *"struck off"* their GP's lists.

In the longer-term beyond Apr.05, the CAT clinics would also be responsible for managing those patients currently in the Shared Care clinics. Planning was underway to arrange the transfer of roughly 5000 clients into citywide CAT clinics over the course of the next year. CATs would hold full responsibility for all patients on Glasgow's methadone programme, albeit this was the not original intention of the integrated strategy.

The former GDPS clinical director ('Dr. Jane') appeared to be supportive of this initiative, despite having become one of several GDPS 'causalities' in the change process[34]. Dr. Jane shared top management's view that the CAT clinics were worth introducing on their structural merits, and that the quality of care patients would receive might be better in comparison to the standard of care that they received in Shared Care.

"The main advantage for me is that there will be a consistency of approach. There will be much more control over patients now. I think if you have a centrally managed department it is bound to be better. Clinical governance issues will be easier to control. Patients will no longer just be getting repeat prescriptions, and they will get reviewed regularly."

(Dr. Jane, former GDPS, Community Health)

However, it was clear from the narratives of other Community Health managers that the primary justification for moving all methadone clients into a service managed by CATs was that *"an alternative service would be cheaper."* The actions of top management suggested that they did not believe that they would get value for money if they remunerated GPs with a £350 enhanced services payment for prescribing and monitoring methadone therapy. Although NHSGG executives had agreed to pay GPs £350 up until 1st Apr.05, they were reluctant to extend the arrangement for the long-term. Furthermore, they decided to 'cap' the number of patients that Shared Care GPs prescribed for during the Apr.04 – Apr.05 period. In doing so, NHSGG effectively prevented Shared Care GPs from increasing their practice revenues by prescribing methadone for any more patients than they were currently prescribing for.

"The nationally agreed figure per patient is £350, but because of the huge number in Glasgow on methadone, we can't afford to pay that. There have been negotiations with the GPs involved in Shared Care to see if they would accept a bit less, but they have said 'absolutely not'. So, we now have to cap that programme. They can't take on any new people.

[34] Shortly after her Time 2 interview, Dr. Jane resigned. There was no indication from Time 1 or Time 2 interview data that she planned to do so. Prior to commencing the Time 2 interview, she announced that a medical colleague would sit in on the taped interview. It was not revealed to the researcher at the time that this doctor was a high-level representative of British Medical Association. This request was granted without any objection. The BMA representative sat quietly while taking notes of the interview throughout. During the interview, there were a number of change-related issues that Dr. Jane was "*not prepared to discuss*." These issues specifically concerned the 'bridge agency' issue, and the long-term future of the methadone programme. Data from a medical colleague of Dr. Jane helped shed some light on why she felt it necessary to have professional representation at the interview. She was now in dispute with NHSGG because she no longer held a major role under the new service structure, and because *"the alternative offered to her wasn't suitable."* Speaking out against the CAT clinic model may have jeopardized her position when she was currently in dispute with NHSGG about being displaced, or disposed of, as part of the restructuring process.

The implications for the CATs are that they will have to be responsible for any new patients looking for methadone." (Dr. Jane, former GDPS, Community Health)

Amid rumours that the GPs from Shared Care were considering *"pulling out of the methadone programme en masse,"* the CAT clinic model was still to be introduced due to the budgetary pressures faced by NHSGG executives. Despite concerns that *"the bitter GPs might take the hump"* and strike methadone patients off their practice lists, top management believed that introducing the CAT model was a risk worth taking.

However, a major limitation of the new model was that the CAT clinics had, as yet, no medical support, unlike the former GDPS or Shared Care clinics. Top management were aware that this particular issue was *"a drawback"* of the CAT clinics due to *"the disassociation of the patient from their GP and general medical services."* CATs potentially faced *"ending up with a whole bunch of people on methadone who would not be linked to a GP to take care of their everyday medical needs."*

By May.04, the CAT clinics were getting *"busier and busier."* They were *"bringing many more patients in, but none were going back out."* To compound matters, there were no GPs for CAT clinic managers to send patients back to due to the capping system now in operation for Shared Care GPs. Furthermore, there were no longer any prescribing doctors available to help support the demand for methadone therapy. This coincided with Dr. Jane's resignation, and those of other GDPS doctors which soon followed during May.04, whom top management anticipated would provide a 'bridging role' for CATs during this period. The general view was that the methadone programme was now *"at crisis point."* Consequently, top management began a recruitment campaign to find doctors that would be contracted solely to prescribe methadone within the new CAT clinics.

"We were thin on the ground for medical cover in the first place, but there are now even less doctors to cope as GDPS has been dissolved. No funding was ever provided to the CATs for additional medical cover, so everything is really being brought to a climax now because of this whole GP contract issue. The CATs have no other option but to retain more patients. This is now going to become the main issue for the CATs. It is all about retaining and treating patients now." (Dr. Jane, former GDPS, Community Health)

Shared Care GPs **disapproved** of top managements' initiative to establish an alternative model, and looked on as Specialist Service and CAT managers attempted to cope with the

worsening problems of the methadone programme. The problems of the new CAT clinics left GPs unaffected. The number of patients they looked after in their Shared Care clinics remained the same as the capping system prevented them from bringing new 'stable' patients in, while none were being discharged and moving out. They were aware that an increasing number of patients were trying to access methadone and *"not findings things very easy."* In their view, *"nothing much had changed during the first six months."*

However, two things had changed quite significantly. First, since 1st Apr.04, GPs were now receiving a fee of £350 per head for those same patients that they had previously received £150 to prescribe for, amounting to a 133% increase in their revenues. One GP commented how *"Christmas had come early for them."* Second, GPs had now become castigated by other managers for being *"greedy"* and only concerned about *"the pound signs flashing in front of their eyes."* CAT managers commented how the GPs were *"a fucking nightmare since the contract issue came up."* They were *"cynical"* and *"lacking the goodwill"* to support the methadone programme and contribute towards the exit strategy. GPs were now seen as unscrupulous, mercenary, and uncompassionate.

"The GP contract situation has made things worse. We need more GPs on board with us as opposed to them threatening to pull out." (David, SW, East CAT)

'Specialist Service managers get caught in the crossfire'

Specialist Service managers ability to transfer their clients back into CATs, in order to move them on towards full rehabilitation, was now limited. The *"bottlenecks"* were still there, and moving clients on was even more challenging than it was prior to CATs being introduced. From being highly approving of the concept of an exit strategy at Time 1, these managers had become more **ambivalent** about it happening in practice.

Specialist Service managers were not reaping the rewards from the new strategy in the way that they had hoped. The problems of the GP contract, and CATs not having their full complement of staff in place to cope with client transfers, meant that Specialist Service managers found themselves *"suddenly getting caught in the crossfire of other people's problems."* Although they remained generally supportive of developing an exit strategy, it was *"the politics and the personalities that were now screwing things up."*

SECOND-ORDER ANALYSIS

Example 3: Community Health managers

At Time 2, Community Health managers conferred **low moral legitimacy** upon Goal 1, in its variant form of *structural legitimacy*. In their view, the introduction of the CAT clinic model compromised clinical governance guidelines. It also lacked any clinical leadership since Dr. Jane's resignation from the former GDPS. These managers questioned how a major public health programme, which entailed the prescribing and monitoring of a controlled drug, could be managed without any medical figurehead. There was currently no identifiable line of medical accountability for the management of the methadone programme within the new integrated structure. It was *"all of bit of dog's dinner,"* and *"unprecedented"* that there was such poor organization for a major clinical programme of this scale.

"I couldn't even start to guess who is now managing the whole thing. That's part of the problem. No one is clear at this moment in time if the GPs are solely responsible for these patients duty of care or if its sits with the CATs. No-one had told us this, and from a clinical governance point of view, that's not so clever." (Dr. Richard, GP, Community Health)

Community Health managers also questioned how those senior employees of NHSGG, who were members of the top management team, could propose a model which contravened what was internationally recognized as the best way to support IV drug users in the community i.e. the Shared Care model. They believed that the new CAT model breached what was widely accepted in the addictions field as 'best practice' for managing opiate dependency. Namely, that separating patients from their own GPs was unhelpful to their rehabilitation and the very reason why the Shared Care programme was introduced in Glasgow in the first place.

"The Shared Care system has been good for the patients. It has worked well. We have a lot more stable patients who are still alive at this point in time because of it".

(Dr. Gerry, GP, Community Health)

In the eyes of Community Health managers, the merits of the CAT model were highly negligible. It did not appear to be developed through *"evidence-based practice,"* and therefore did not have the scientific credibility which the Shared Care Scheme had.

"The first port of call for most families and individuals with drug problems is to get help from their family GP. We have a key role to play, and we know this through Public Health research on managing heroin misuse." (Dr. Richard, GP, Community Health)

Community Health managers mocked top managements earlier claims that the methadone programme would be *"patient-centred"* and *"offer the best care possible,"* when it now appeared to them that the decision to introduce the CAT model was a question of affordability. These messages, which top management had publicly declared during Time 1 communication exercises, were now being invalidated.

"This alternative model is not about what is best for the patient. It's all about what they are prepared to pay us. The reason Shared Care is capped is purely a monetary thing, and why this new model has suddenly appeared out of nowhere." (Dr. Paul, GP, Community Health)

Community Health managers expressed **low attitudinal commitment** towards Goal 1. They were deeply pessimistic about that the success of the CAT clinic model and predicted rather catastrophically that it would be *"a disaster."* The "*new poisoned chalice"* would be unworkable, and it would fail because CATs would be *"absolutely inundated"* and have *"huge problems coping."* The impact of moving to a new model would prove to be *"a retrograde step, because people were going to be without methadone in the short term."*

"There are about 5000 in the Shared Care Scheme. If you lump them all into the CATs then the CATs will just be sunk. They will be swamped. It will be time to get behind the barricades and prepare for crisis management because they can't cope in short term, and they won't cope long term when they realize what's hit them." (Dr. Paul, GP, Community Health)

<u>Second-order analysis point</u>

At Time 2, Community Health managers' narratives suggested that the L-C relationship was reciprocal. For example:

(7: CH) Low moral *(structural)* legitimacy coexisted with low attitudinal commitment.

Example 4: Specialist Service managers

Specialist Service managers conferred **low moral legitimacy**, in its variant forms of *consequential* and *structural legitimacy*. On a consequential level, the proposed exit strategy, which promoted the movement of clients from Specialist Services into the CATs and then out

of the addiction service altogether, had not materialized. The CATs had *"not lived up to their potential,"* and the integrated strategy was not accomplishing what it had promised. As a result of the problems associated with the GP contract creating a *"massive knock-on effect"* for their own services, these managers described how they were still operating as *"a holding service"* in much the same way as they had done prior to Time 1.

For example, 'Maria' the Drug Court manager could not move clients on into CATs whose court orders that were due to expire. Even when some were eventually transferred to CATs, they were *"not getting picked up quickly enough"* by CAT managers. Similarly, the Crisis Centre manager reported how *"things were happening a bit slower than before"* in relation to CAT managers ability to identify a prescribing doctor to whom their clients could be transferred over to.

The HAT manager experienced the most problems. Clients who were ready to move on to CATs could not be easily transferred. This was due to the emergent 'buffering' practices of CAT managers refusing to accept HAT referrals. The HAT manager found it impossible to move clients on in the way that the integrated strategy promised.

Some Specialist Service managers had to adapt their own operations to deal with the backflow and the *"new kind of bottleneck"* that had emerged. The Drug Court, the Crisis Centre, the WRHS (Women's Reproductive Health Service), and the HAT, were all now holding on to clients purely because they had their own 'on-site' methadone prescriber. Even though their clients were ready to move on, they could not be taken on by Shared Care GPs whose prescribing had been capped, or the now defunct GDPS.

Top management decided to put in place temporary *"private arrangements"* with each of these services. Specialist Service managers did not look favourably upon these arrangements as there was no indication from top management about long they would be required to remain in place.

"We have ended up shielding the CATs from their problems getting worse. We now have 140 individuals who are not homeless and who have their own tenancies. They should now be looked after by the CATs, but the CATs can't, or won't, take over their prescriptions. So, the ones who should be moved on are still here six months after the CATs have been set up."

(John, HAT, Specialist Service)

On a structural level, the CAT clinic model seemed to be a *"one-size-fits-all"* approach to methadone management, and which failed to take into account the different needs of different types of clients. For example, 'Dr. Mary' the obstetrician from the WRHS, strongly objected to the CAT clinic model as it was *"entirely inappropriate"* to disassociate mothers from their family GP. She described her *"absolute horror"* about the prospect of mothers with new babies being managed within CAT clinics, instead of mother and baby being handed back to a GP in *"the way it should be done."*

"Women with a brand new baby need to be looked after in a General Practice where the rest of the family health care is given. Now, great as the CATs may be, it is not the place for a woman with a brand new baby. If they lose their long term care from their family GP, then I think we would have to accept the worst outcomes. There is no point in us giving them super care all the way through pregnancy if it gets disrupted after delivery and they have to go somewhere else other than their family doctor. That would just be an absolute tragedy. To take these women who are very stable, and discharge them from here and send them to the CATs which is full of unstable people, seems to me like a real sad thing to do."

(Dr. Mary, Obstetrician, WRHS, Specialist Service)

Despite their disappointment at the lack of progress with Goal 1, and their general concerns about the direction of the methadone programme, Specialist Service managers continued to show **high behavioural commitment**. Although they had been prevented from carrying out their plans to *"aggressively transfer"* their clients into the CATs, it failed to discourage them from making persistent efforts to move clients on, or seek the support of CATs to assist with the management of complex addiction-related cases. Specialist Service managers vowed to continue attempts to move clients on from the own services over the coming six months.

<u>Second-order analysis point</u>

At Time 2, Specialist Service managers' narratives suggested that the L-C relationship was non-reciprocal. For example:

(8: SS) Low moral *(consequential)* legitimacy coexisted with high behavioural commitment.

(9: SS) Low moral *(structural)* legitimacy coexisted with high behavioural commitment

THIRD-ORDER ANALYSIS

Sub-group: Community Health managers

'From being co-opted in, to being vetoed back out'

What unfolded prior to Time 2, was the public disqualification of GPs from participating in the strategy process. NHSGG advised GPs that any further negotiations around the GP contract, and their future involvement in the methadone programme, would only take place with elected representatives from the BMA[35]. For this reason, Community Health managers conferred **low moral legitimacy**, in its variant form of *procedural legitimacy.*

GPs were left asking, *"We were written into the plan at the start, so why are we not now?"* Some of these managers had initially been heavily co-opted into the strategy development process since the very beginning. Now, Community Health managers had *"no dealings"* with top management with anything that was addiction-service related. All of them commented on how they were now *"kept in the dark"* about the future direction of CATs and the methadone programme.

"Some of us were involved in helping to set up the CATs, and there were good working relationships there. But that seems to have fallen by the wayside to a certain extent. We no longer have the same people actively engaged in the addiction side of things. So the relationships were there, but the CAT managers' position seems to have changed. I don't know what has gone wrong." (Dr. Richard, GP, Community Health)

The implications of exclusion led these managers to ask how they were supposed to participate in developing an exit strategy if they remained *"frozen out,"* and top management were not prepared to directly communicate with them.

"It would be nice if we were having some type of discussion for them to say, 'here is what we thought we were going to do, it's not all good news, this is where we are etc'. But there is no longer that type of engagement." (Lorna, Community Health)

Community Health managers had become concerned that the *"follow-up discussions"* which top management and CAT Operations Managers promised would take place during the first six months had not happened. It left GPs feeling *"let down"* that *"promises were not kept."*

[35] Further negotiations were scheduled and re-scheduled. The current position was that negotiation talks would take place before the end of 2004.

"We sat there listening to them spouting all the stuff from Joint Futures"[36] and Partnership for Care[37], and about how service development was all about consultation, participation, inclusion and all the rest of it. Well, things have gone rather quiet as far as all that is concerned." (Dr. Paul, GP, Community Health)

'The backlash to exclusion'

Although Community Health managers talked of *"waiting to see what the endgame is,"* and that *"common sense would prevail,"* they reacted angrily to their exclusion from the strategy process. They responded to top management's decision to introduce the CAT clinic model by demonstrating **low behavioural commitment** to Goal 1. GPs collectively agreed to refuse ongoing requests from CAT managers to accept some of their patients from CAT clinics (who had been stabilized) back into Shared Care clinics.

GPs also decided that they would now instruct all of their patients who made [new] requests for methadone to 'self-refer' to CATs, In addition to this measure, they decided that those patients in the Shared Care Scheme who were *"relapsing"* and *"struggling"* with addiction-related physical and mental health problems, would also be instructed to go to the CATs for help, even though GPs were now being paid £350 to manage these patients themselves.

"We will send them all to the CATs. Let them sort it out. They'll be the ones who'll decide what happens to these patients. It's now over to them." (Dr. Paul, GP, Community Health)

GPs felt they had *"some time on their side,"* and that it was not in their interests to co-operate with the CATs if they were not going to be paid the £350 fee beyond Apr.05. They appeared to suggest that they were applying some pressure on the system to increase their negotiating position come the next round of contract negotiations, even though their action had the effect of compounding capacity management problems, and was known to anger top management and CAT managers.

"We would like to carry on with Shared Care, but I think we have taken a long term view. We have to take the hard line if we are to keep the Scheme going."

(Dr. Gerry, GP, Community Health)

[36] The Joint Future Strategy was initiated by the Scottish Government in Dec.1999. It provided the basis for all integrated service projects undertaken by Health and Local Authorities in Scotland in the following years (see Appendix 1).

[37] NHS White Paper: Partnership for Care (2003) described how future policy developments in the NHS would always place the views of clinicians at the centre of any new initiatives (see Appendix 2).

'Justifying en route action on institutional grounds'

Community Health managers narratives attempted to put the reasons for their **low behavioural commitment** into context. They protested that the root causes of the conflict with NHSGG were not manufactured by Glasgow's GPs. They began distancing themselves from the detail of what had been negotiated at government level, and that GPs in Glasgow had not personally been driving the agenda for an enhanced payment rise to £350. In doing so, they continually reverted back to the point that the GP contract was *"a national agreement, and not a local dispute,"* and that it had to be viewed "*as part of the bigger national picture."* From their perspective, there was *"a requirement"* of NHSGG to accept the agreement that the BMA had made with the UK government.

"This issue came completely out of the blue. Everything was going swimmingly with the CAT plan till the funding issue came up. But the enhanced services fee was agreed as part of a UK-wide contract. It came out of the woods, and it has thrown out the Health Board's calculations. With the short notice, you could see where the Health Board are coming from by saying 'we can't afford it'. But we are saying, 'well, this is the agreed price'."

(Dr. Paul, GP, Community Health)

GPs maintained that they did not want to resort to the type of action that they were now taking. Neither did they want to withdraw from providing general medical services which made them feel *"uncomfortable,"* but they felt that they had little option to do much else. They were prepared to take *"controversial steps"* if it meant *"bringing the contract back to the negotiating table."* They argued that they were only taking *"the hard line"* by acting on the guidance of their Local Medical Committee (i.e. BMA representatives), and highlighted how they had the support and backing of an established professional body for the position that they were taking.

"The difficult part of all this is that we have to make it clear to some patients who want to join our practice that we would not be able to offer them any help with their IV drug problem. We are not happy about having to do that, but our hands are tied".

(Dr. Richard, GP, Community Health)

"We've been hearing that Shared Care will be taken away if we don't agree to the price they are offering us. If that's the case, I want out of it. If all the other quality stuff with the patients is not getting done, I would probably put them off my list. I would have the right to say, 'we

are not getting paid for it, so we are no longer doing it'. No-one wants that to happen."

(Dr. Gerry, GP, Community Health)

GPs were prepared to stand their ground. They had become frustrated that top management expected them to take on patients for a fee which fell far short of what the BMA had already agreed. They remained unwilling to accept anything less than £350 per patient. To do so, they argued, had wider implications for the GP contract, not just in Glasgow, but in Scotland and the rest of the UK. To locally negotiate a fee of less than £350 had ramifications for their fellow GPs outwith Glasgow.

Glasgow's GPs maintained that they were not in a position to agree a local arrangement, and that they felt constrained from doing so. It would undermine the principals of the contract and the reasons why a nationally-agreed contract was initiated by the BMA and the UK government in the first place (i.e. to avoid local disparity in enhanced service payments across the UK). By consenting to a locally-agreed fee of £150, or even £250, meant that they would be *"breaking ranks"* with their GP colleagues nationwide. They were not prepared to take this type of action, even if it adversely affected the integrated strategy and *"sunk the CATs."*

"*This is a political football and it could throw the CATs completely off-course. But there is a lot of bad feeling over the contract, because the Health Board feel that they are being held to ransom, and we are saying, 'well the contract has come in on the 1st April 2004 and it has all been agreed' so all of this needn't have happened. I mean, the best thing is to have a lot of the methadone programme under the care of GPs with Shared Care, but it is a political argument that is at the root of the situation, and it comes down to us and the Health Board. The contract and the methadone issue could completely scupper the CATs and the methadone service."*

(Dr. Paul, GP, Community Health)

<u>Third-order analysis point</u>

Community Health manager's third-order evaluations did not change the nature of the L-C relationship, as it remained reciprocal. For example:

(10: CH) Low moral *(procedural)* legitimacy coexisted with low behavioural commitment

(11: CH) Low moral *(procedural)* legitimacy coexisted with low attitudinal commitment

(12: CH) Low moral *(structural)* legitimacy coexisted with low behavioural commitment.

Sub-group: Specialist Service managers

'Where the bloody hell has the GDPS gone?'

Specialist Service managers no longer conferred high cognitive legitimacy upon Goal 1 as they had done at Time 1. The emergent decision by top management to dismantle the GDPS and cap Shared Care shifted their evaluations towards **low cognitive legitimacy**, as they were perplexed by the logic underpinning such a decision. They questioned how Goal 1 was feasible when CATs had no medical support to provide methadone therapy, or how an effective exit strategy could be developed without the input of GPs. They were particularly concerned about how the general medical needs of complex addiction-related cases were going to be provided, as there was no GP for them to go back to under the new CAT model.

"There is now a major question mark over the CATs ability and capacity to offer methadone prescriptions." (John, HAT, Specialist Service)

"Tell me, where are these patients supposed to go if they can't go back to their GP? What about the ones who don't have a GP or one that won't prescribe methadone? And where the bloody hell has the GDPS gone? (Dr. Mary, Obstetrician, WRHS, Specialist Service)

'Discovering the rules have changed somewhere along the line'

Specialist Service managers also conferred **low moral legitimacy**, in its variant form of *procedural legitimacy*. None of them had been formally advised by top management about the changes to the methadone programme. Many discovered how things had changed as they attempted to transfer clients into CATs. They protested that they *"should have known in advance about what was going to happen."*

The *"poor communication"* around such an important element of the CAT strategy being changed en route, without them receiving formal notice, inspired little confidence in top management. In some cases, Specialist Service managers found themselves actively seeking out information about en route developments to gain some understanding about what was going on elsewhere and how it might affect their own services.

They were particularly unhappy about *"how the rules seemed to have changed somewhere along the line."* They found themselves constantly having to negotiate the transfer of clients into CATs , when it had already been outlined in the strategy document that the CATs were set up to serve this purpose. These negotiations caused them frustration, and frequently resulted in *"some rather heated arguments"* with CAT managers.

Sean ('Children & Families') and Dr. Mary ('WRHS') were *"extremely concerned"* that the matter of dealing with pre and post natal mothers, or those mothers with children who had relapsed, had not been considered or formally planned before the CAT model was introduced. Both complained that the practice of managing complex clients on a case-by-case basis en route was *"a real concern,"* as it *"ran the risk of losing consistency for those who were most vulnerable."*

'Looking upwards for inspiration and guidance'

Specialist Service managers began calling for more planning, and less emergent strategizing. The need to formally address the finer details of the CAT exit strategy in a formally planned fashion had become more urgent.

"There has been a lot of 'let's see how things go' and 'let's try and find our way' and 'let things bed down'. But I think that we now need to work a bit more on what the structure actually is, how we support that structure, and how we deal with the development and communication issues. So far, they have been dealt with in an ad hoc way. It would be good if we spent a day away thinking our way through what the issues are in order to say, 'here is our action plan for the next six months."

(Sean, Children & Families / Criminal Justice, Specialist Service)

Ongoing problems with transferring clients into CATs could not be resolved and Specialist Service and CAT managers could not negotiate a solution to the problem. From the Specialist Service manager's perspectives, the concept of an exit strategy, which had been enshrined in the CAT strategy document, appeared *"lost"* on CAT managers.

They reported that the East and NE CAT Operations Managers appeared reluctant to get involved in any dialogue about formalizing the finer details of the exit strategy, as they seemed to *"have a real fear about what was coming to them."* Specialist Service managers suggested that top management, and CAT Operations Managers, needed to engage in a dialogue with them about the finer details of Goal 1 *"before things got a bit messy."* The

espoused elements of the strategy now required top management intervention, they argued, because what was deliberately-planned was now being regularly disputed by CAT middle managers.

"There has to be an agreed approach. If there is not, we simply can't get people moved on. We need to formalize things" (John, HAT, Specialist Service)

Specialist Service managers subsequently sought the counsel of top management to actively intervene. The request was not for them to arbitrate, but for them to *"flesh out some of the detail"* about how they envisaged the exit strategy should work in practice, and how CAT and Specialist Service managers ought to proceed. Top management soon began holding formal discussions with each Specialist Service manager.

One such example where top management intervention became necessary was due to increasing tension between the HAT and East and NE CATs. Ongoing disputes over the transfer of clients from the HAT to the CATs, and vice versa, had culminated in *"too many bun fights"* and *"a bit of a stand-off."* A planning meeting was organized during Mar.03 which involved CAT Operations Managers, the HAT manager, and a member of the top management team. The meeting resulted in the development of the 'Homelessness Interface Protocol,' which outlined who was responsible for which clients in different sets of 'homelessness' circumstances.

Following the meeting, top management issued an edict to all CAT managers. They elaborated upon the broad principles of the exit strategy in more detail, specifically concerning how CATs should work together with the HAT. The edict was explicit about the roles and responsibilities of each agency, as well as setting out more clearly where each service's boundaries overlapped or differed.

'Intervention from above reignites hope and optimism'

The reaction of Specialist Service managers to top management edicts turned out to be very positive. It created renewed optimism among this group of managers that pursuing an exit strategy was *"still a worthwhile cause."* It offered them assurances that the *"major hitches"* of the first six months would be avoided in the future, and *"that CATs would begin to live up to their potential."* Therefore, following top managements' intervention, Specialist Service managers subsequently expressed **high attitudinal commitment**.

"They are now acknowledging the specialist needs of pregnant women and new mothers only because I got on my soap box and started shouting so loudly about it. But now, they are very keen to develop this side of things." (Dr. Mary, Obstetrician, WRHS, Specialist Service)

Third-order analysis point

Specialist Service manager's third-order evaluations did not change the nature of the L-C relationship, as it remained non-reciprocal. For example:

(13: SS) Low moral *(consequential)* legitimacy coexisted with high attitudinal commitment

(14: SS) Low cognitive *(comprehensibility)* legitimacy coexisted with high behavioural commitment

(15: SS) Low moral *(procedural)* legitimacy coexisted with high behavioural commitment

(16: SS) Low moral *(structural)* legitimacy coexisted with high attitudinal commitment

TIME 3 (December.04)

FIRST-ORDER ANALYSIS

'It was always murder to get on methadone...and it's still murder to get off it'

By Time 3, the problems associated with the methadone programme had got significantly worse. There were now *"far more scripts being requested, but far less doctors to prescribe for all those coming through the doors."*

To help address the lack of medical support for CAT clinics, NHSGG sought the help of 'Dr. Robert', who was a former GDPS GP and currently the 'on-site' prescriber for the HAT. He reluctantly agreed to temporarily provide medical support to CAT clinics in the East and NE of the city. However, this proved to be a demanding role. By having one doctor prescribing methadone for several hundred clients carried with it the increased likelihood of prescribing errors occurring.

Eventually, more doctors were *"drafted in"* to help prescribe within the busiest clinics. These doctors were psychiatrists who had not previously been involved with the methadone programme. Had Dr. Robert and others failed to support the CAT clinics in the interim, methadone therapy would no longer have been made available at CAT clinics. The CAT clinics would have collapsed, and a public health crisis was predicted if methadone treatment for Glasgow's unstable opiate-dependent population had been abruptly discontinued.

"It's pretty difficult to explain to somebody from the outside what I'm actually doing in this role, because the GDPS is now completely gone. But if I don't prescribe for those poor buggers in the CAT clinics, then who is going to do it? Can we really afford to leave these all these punters in the lurch? I don't think so." (Dr. Robert, Community Health)

The consequences of drafting in different doctors on a sessional basis were two-fold. First, clients no longer received any continuity to their medical care. Second, their overall progress was not reviewed in any systematic way to assess their eligibility for moving towards full rehabilitation.

Shared Care GPs remained isolated and excluded from the strategy process. They were still adamant that they would not provide their enhanced services to NHSGG beyond Apr.05

unless the terms and conditions of the nationally-agreed GP contract were met.[38] Therefore, they continued to be **disapproving** of Goal 1.

Due to the capping system, the same patients were still attending Shared Care clinics at Time 3, as they were at Time 1 and 2. None had moved on to full rehabilitation in the past year. On the contrary, many had relapsed and required more intensive input from CATs. One GP summarized the status quo by commenting, *"It was always murder to get on methadone, and it's still murder to get off it now with the way things have ended up."*

'Still no exit strategy one year on'

Specialist Service managers were **ambivalent** about the prospect of successfully implementing Goal 1. Although they remained supportive of the need to pursue the development of an exit strategy, there were few signs that the introduction of CATs had made any impact upon moving clients along the path towards full rehabilitation. The GP contract dispute, and its impact on their own services, was cited as a major contributing factor to little progress being made.

"The problems haven't changed since a year ago. They are still there. There is still the ongoing problem of getting medical staff to prescribe methadone. So the major gap for addiction services remains. We have no exit strategy." (John, HAT, Specialist Service)

SECOND-ORDER ANALYSIS

Example 5: Community Health managers

Community Health managers conferred **low moral legitimacy** upon Goal 1, in its variant forms of *structural* and *consequential legitimacy*. On a *structural* level, they reiterated their arguments against placing patients into the CAT clinics where there was no consistent or continuous input to manage the patient's everyday general medical needs, and no clinical evidence that the new model was the best way to manage opiate misuse.

"As evidence based practice, I think the jury's out. I don't think anybody has shown me any convincing bit of evidence that this actually works. The alternative model is absolutely crazy. It has effectively turned the CATs into a specialist service. It is no longer the community level service that it was supposed to be. A specialist service is fine to meet an acute need, but I

[38] GP negotiations which were set for Oct.04 were continually delayed and rescheduled. They did not occur until after Time 3 and into Jan.05 when the evaluation process was completed.

don't think they should be the ones that are handling the patients' care for the rest of their lives. I think it's madness to try and expand a huge scheme that provides methadone under the CAT clinic model. It's entirely the wrong place to put patients. The sooner they are returned to their GP and prescribed from there the better."

(Dr. Robert, GP, Community Health)

When comparing the CAT clinic model to the former GDPS model and *"the flaws of Shared Care,"* Community Health managers argued that the old service provided a two-tier process which delineated at what stage the patient was at in terms of 'stable' or 'unstable'. By "*throwing all the patients into the one pot"* made it difficult for clinicians to define at what stage each individual was at in their recovery. Any attempt by CAT managers to address this issue, with the high number of patients they were now responsible for, *"would take years."*

"At the moment, the standard of the methadone programme is much poorer. All the patients seem to be going into one great big black hole. At least there was already something in place which was working, and although it might not have been working terribly well, or as well as how the CATs working with Shared Care GPs was expected to go as outlined in the original plan, it was working better than the model we have now." (Lorna, Community Health)

"For all its faults, the Shared Cared Scheme in Glasgow was actually a world leader in terms of integrating medical and social care. We've sort of thrown out the baby with the bathwater there. There was no waiting list as such. The GPs were all involved. You could see the patients were on the right path once they got out of the GDPS, and they were going back to their GPs." (Dr. Robert, GP, Community Health)

On a *consequential* level, there was a sense of déjà vu about GPs narratives' on the subject of the exit strategy one year on. CATs had not accomplished what they set out to do. Instead of focusing on moving existing clients towards full rehabilitation, the opposite appeared to be happening as *"everyone was spending all their time and effort getting people into treatment, not out of it."* The absence of an exit strategy for those on methadone was apparent to all of these managers.

"I think we really need to be looking at moving people on. There are employment issues and a whole load of other issues, because at the moment, what we seem to be doing is getting people in, getting them care and it's just mushrooming and we've got this whole group of

people that are stuck at the moment. We really need to focus on how we can get them through the other end." (Dr. Richard, GP, Community Health)

"An exit strategy for the IV drug users hasn't been developed. Neither has there been anything to just help them stay totally clean. It is all very well keeping them pumped up on methadone, but it doesn't get them out into society and living normal lives again."

(Bill, Community Health)

Community Health managers expressed **low attitudinal commitment** as they had done at Time 2, however, they were even more pessimistic about the prospect of Goal 1 being achieved in following six months due to the multiple problems that CATs now faced. Their expectations of success were lower because "*things were worse now than they were before,"* and as *"CATs were still finding their feet."*

"It is taking a long time to actually get to the stage where you can see some light at the end of the tunnel." (Kenny, Community Health)

"There are problems just now, and they will get even more overwhelmed by numbers. They don't have the resources to cope. It doesn't look good for them"

(Dr. Paul, GP, Community Health)

GPs predicted that CATs would become so pre-occupied with managing new unstable clients coming into the system, that there would be no scope for working with stable cases in order to move them out.

"I think they've probably underestimated the work load and the nature of the work that they're doing. They are really going to struggle. That's just the impression I'm getting from the pressure that they seem to be under." (Dr. Richard, GP, Community Health)

<u>Second-order analysis point</u>

At Time 3, Community Health managers' narratives suggested that the L-C relationship was reciprocal. For example:

(17: CH) Low moral *(structural)* legitimacy coexisted with low attitudinal commitment.

(18: CH) Low moral *(consequential)* legitimacy coexisted with low attitudinal commitment.

Example 6: Specialist Service managers

Specialist Service managers conferred **low moral legitimacy**, in the variant forms of *consequential* and *structural legitimacy.* On a consequential level, Specialist Services continued to play the 'holding role' that they had done prior to Time 1. Clients ended up remaining in the care of Specialist Services when they did not require to, and for much longer periods in comparison to before CATs were introduced.

Specialist Service managers also cited many examples where CAT managers appeared to be shifting the onus and responsibility for 'stable' cases on them, simply because they could no longer cope with the CAT and Shared Care clinics. Many found that the burden of care was being foisted back onto Specialist Services, and that CAT managers were pushing clients further back into the system instead of taking them on and moving them out the other way. This was the opposite of what the strategy intended. Rather than moving towards the exit, clients were moving in the other direction.

"Because the CATs have no doctor available to prescribe for patients that I want to discharge, I've held on to some women in post-natal care for over a month longer that is normally required. It is not the maternity hospital's responsibility to keep them on for prescribing methadone once mothers have had their baby."

(Dr. Mary, Obstetrician, WRHS, Specialist Service)

"It should be a swift transfer from us to the CAT. We should be able to take homeless people on, treat them, identify the area that the person wants to move back into, arrange accommodation, and be able to say with some confidence that CATs will pick up their prescribing. We can't do that. You have to then negotiate with the CAT managers who say, 'we can't take on the person's care because we can't find them a prescription'."

(John, HAT, Specialist Service)

Because their agencies had tried to alleviate the problems of the CAT at Time 2, Specialist Service managers had become worried that they had set a precedent, and sent out the message to CAT managers that temporary arrangements to hold on to clients could become permanent and longer-term. For example, the HAT manager believed that CAT managers were now abusing the Homelessness Interface Protocol for their own means, and that *"things were still turning out to be a bit of a one-way street."*

"As soon as we take somebody on for say methadone prescribing, the CATs then become very reluctant to take their responsibility. We are saying, 'hold on, we are just taking this person on to give you a bit of breathing space and to organise the appropriate care'. Some people think, 'well the HAT has been prescribing for them, why should we bother taking them back at all?'" (John, HAT, Specialist Service)

The general consensus from this group of managers was that the introduction of CATs had yet to make any impact on moving people on towards full rehabilitation as intended. On the contrary, finding a prescribing doctor had become more difficult than before due to the capping system on GPs and the GP contract issue. There was no longer the option to move clients out of Specialist Services quickly as medical cover for CATs was now operating at a critically low level.

"Clearly, we have not yet reached the stage in the process that we would have expected" (Dr. Mary, Obstetrician, WRHS, Specialist Service)

"The new structure had probably yet to show its teeth in many respects. I have not seen a major impact in relation to moving people towards a full recovery." (Sean, Children & Families / Criminal Justice, Specialist Service)

On a structural level, Specialist Service managers argued that there was more evidence to suggest that the CAT clinic model had made a negative impact on the development of an exit strategy. The difficult transition from taking over the former GDPS clinics, dealing with the uncertainty of the GP contract issue, and the CATs not being resourced properly from the beginning, were all cited as reasons why Goal 1 had not succeeded.

"They have dismantled major parts of the old service structure. No matter how good or bad they were, there was a definite structure in terms of how you would get into the GDPS etc and people knew that. Now it's been replaced with something that is new, but we don't know how to use that new structure. It doesn't seem capable of taking on all the things it is required to." (John, HAT, Specialist Service)

Concerns remained about the methadone service being able to run properly when no permanent prescribers were deployed within CATs clinics. In the opinion of Specialist Service managers, Shared Care GPs were considered to be a crucial element of the methadone service structure, and their long-term exclusion from it was expected to have

"dire consequences." Therefore, the success of CATs would be dependent on resolving the GP contract issue.

"Everything will depend entirely on having a huge bank of GPs. If you lose Shared Care GPs, then all those patients will go to CATs and they are going to be flooded. I think that will jeopardise their success." (Dr. Mary, Obstetrician, WRHS, Specialist Service)

Many believed that the reason why Specialist Services were unable to move people on was because of the internal structures within the CATs, namely, the lack of robust criteria for transferring cases back into CATs and how the access and allocations process was set up.

"The referral criteria into CATs has to be tidied up a wee bit, because there are some inconsistencies about where the nurses sees themselves fitting in with child protection issues and what it is they do to help people recover."

(Sean, Children & Families / Criminal Justice, Specialist Service)

CAT managers were found to be *"inconsistent"* around which cases they would sanction for transfer. It was becoming apparent to Specialist Service managers that the lack of coordination and organization within the teams meant that some clients were not moving towards rehabilitation at all, but *"falling out of the system instead."* For example, the Drug Court manager reported how 'priority cases' were *"getting lost"* in transfer due to the CATs allocation process.

"Transfers have not been working as smoothly as they should have. They will prioritize someone who is still on a court order, but if the clients' order was just coming to an end, or had expired but still needed follow-up support, they were going into a black hole in a general allocations pot. This meant there was often a delay in these cases getting picked up. The referrals were being made, but the bodies never arrive. This group are getting lost in the system." (Maria, Drug Court, Specialist Service)

Specialist Service managers also conferred **low pragmatic legitimacy** upon Goal 1, in its variant form of *exchange legitimacy*. In contrast to Time 1, the terms of the exit strategy were no longer quite so favourable to them. By contributing to its development had adversely affected them in a financial and operational sense. The HAT was most affected, as their on-site prescriber, Dr. Robert, was now prescribing for the CAT clinics.

"Dr. Robert is now the Responsible Medical Officer for the CATs. He now spends 75% of his time outwith this service which then impinges on the service that we can provide. We are using the same resources and spreading them even thinner. It doesn't allow us to develop the service here, when a key component of our service is actually serving a major function the CATs." (John, HAT, Specialist Service)

"We can't go on indefinitely looking after these women if the cost of their care is coming from the maternity hospital budget." (Dr. Mary, Obstetrician, WRHS, Specialist Service)

Despite all of the above issues, Specialist Service managers continued to signal **high behavioural commitment** to Goal 1. They were well aware of the problems the CATs were experiencing, but nevertheless, they had not yet given up on trying moving stable clients into CATs.

Second-order analysis point

At Time 3, Specialist Service managers' narratives suggested that the L-C relationship was non-reciprocal. For example:

(19: SS) Low moral *(consequential)* legitimacy coexisted with high behavioural commitment

(20: SS) Low moral *(structural)* legitimacy coexisted with high behavioural commitment

(21: SS) Low pragmatic *(exchange)* legitimacy coexisted with high behavioural commitment.

THIRD-ORDER ANALYSIS

Sub-group: Community Health managers

'The perils of strategizing on the hoof'

Community Health managers Time 3 third-order findings confirmed those of Time 2. They continued to confer **low moral legitimacy**, in its variant form of *procedural legitimacy*. GPs remained unhappy about their ongoing exclusion from the strategy process. They were no longer being formally advised of en route developments, and all informal communications links with top management had ceased. They were left frustrated that there was *"no*

dialogue" or any desire from top management to address the problems of the methadone service by including GPs in its development. In their view, *"the trail had gone cold."*

They also continued to question the robustness of the strategy-making process. The general management of the methadone programme, and both parent organizations failure to develop an exit strategy during the past year, was also attributed to poor organization on the part of top management. Regardless of whether emergent activity was enshrined in the broad principles or not, the transition to CAT clinics had been *"less than smooth,*" as CATs were accused of *"trying to do too much at once."* The lack of top management guidance during the emergent process was cited as a key factor in *"the downfall of the CATs."*

"They should have thought hard in relation to clinical governance, accountability frameworks, and all that kind of stuff, and given the teams a much more robust framework for the methadone service. A lot of the things that the teams have put up with are things that the guys at the top didn't provide answers to. It was a case of, 'well these things will be worked out'. Some things had to be worked out on hoof, but the teams needed to be given more help from the start." (Bill, Community Health)

"The protocols for the CAT clinics hadn't been agreed as the clinics started up. In an ideal situation, you would have liked to have seen the CATs not bringing patients in until they've all agreed how the system is going to work, and they've agreed upon who's going to do what. Things were not done so well at all." (Dr. Robert, GP, Community Health)

A consistent criticism was that the CAT model had been introduced without any firm operational plans and enough staff resources in place to cope with demand. Poor anticipation of the wider problems associated with the transition to the CAT model without enough staff suggested to Community Health managers that *"it was no great surprise that the teams struggled badly once the floodgates were opened."*

"The recruitment could have been done a bit quicker. It would have worked better if people had been in position from the very beginning. They could have been a bit smarter by anticipating further down the line what was happening by getting more robust job descriptions agreed early doors," (Kenny, Community Health)

'The strategic aim gets lost somewhere along the line'

Community Health managers also conferred **low cognitive legitimacy**, as they had done at T1, in its variant form of *poor comprehensibility*. As change unfolded, it had become difficult for Community Health managers to distinguish between what was deliberately-planned at the start of the implementation process versus what was considered as emergent. Any clarity on what the strategic priorities were throughout the first year was difficult to establish. These managers sensed that the current preoccupation with managing capacity issues suggested that the exit strategy *"seemed to have got lost somewhere along the line."*

"At one stage, it all seemed to be about the pounds, shillings, and pence of the Health Board. Then it was an alternative model. Then it was our relapsing patients getting sent back to us. It has all been higilty-pigilty. That was not good for us. It is bad for morale when you are not quite sure what is coming next." (Dr. Paul, GP, Community Health)

'The unrepentant and uncommitted excluded strategists'

Community Health managers conferred **low pragmatic legitimacy**, in its variant form of *exchange legitimacy*. GPs Time 3 narratives' did not suggest that they were the *"money-grabbing"* mercenaries that top management and CAT managers portrayed them to be. Several referred to top managements' future plans for the methadone service as *"lifting the burden from them," "decreasing the workload for their practices,"* and *"giving them less problems with the drug users annoying the other patients in the waiting rooms."*

They shared the view that the methadone programme was *"a whole different ball game now,"* and that their participation in helping resolve capacity problems and develop an exit strategy no longer seemed as appealing to them, even with the £350 enhanced fee. In light of the problems over the last year, becoming associated with *"the chaos"* was not such an attractive proposition anymore.

Community Health managers continued to demonstrate **low behavioural commitment** towards Goal 1. GPs had become frustrated by the fact that top management and CAT managers failed to recognize or understand that GPs reluctance to negotiate a local agreement with NHSGG executives had wider national implications for the GP contract itself and their medical colleagues elsewhere. They argued that top management should be seen as culpable for the problems of the methadone programme, not the GPs. It was not the GPs who "*set everything up to happen and then pulled the plug because of budget constraints."*

Community Health managers continued to point out that it was NHSGG executives who reneged on a national-level agreement, and that GPs were only asking for the enhanced services fees that had been agreed by the BMA and the UK government. If NHSGG executives had complied with the conditions of the GP contract, they argued, there would not have been the problems with the methadone programme and its exit strategy that had since ensued over the past year. They were quite unrepentant, and repeatedly emphasized how their actions had to be put into a wider context beyond the local conflict.

"The contract issue has probably created this tension because we are looking for the national contract fee, and Glasgow has such a big problem with addiction. There is a different position from the supplier group and the contractor group, and we are saying 'no, this is nationally agreed. It is not our fault that there is a bigger problem with drugs in Glasgow compared to Wiltshire or Derbyshire', you know?" (Dr. Gerry, GP, Community Health)

"The longer-term issue is ongoing, and I think that's disheartening at times for GPs because we've been put on hold for some time now. For a long time we were told the care we were providing was of a 'gold standard' and eventually it came down to cost and we didn't set the cost. The costs were agreed nationally." (Dr. Richard, GP, Community Health)

"The GP contract came at the worst possible timing for CATs, but they completely shot themselves in the foot. We are not that much further forward. It is very much the status quo that has prevailed, even though the medical side of what was GDPS is in turmoil, and that has not helped matters." (Dr. Paul, GP, Community Health)

<u>Third-order analysis point</u>

Community Health manager's third-order evaluations did not change the nature of the L-C relationship, as it remained reciprocal. For example:

(22: CH) Low moral *(procedural)* legitimacy coexisted with low behavioural commitment

(23: CH) Low cognitive *(comprehensibility)* legitimacy coexisted with low behavioural commitment

(24: CH) Low pragmatic *(exchange)* legitimacy coexisted with low behavioural commitment

(25: CH) Low moral *(procedural)* legitimacy coexisted with low attitudinal commitment

(26: CH) Low cognitive *(comprehensibility)* coexisted with low attitudinal commitment

(27: CH) Low pragmatic *(exchange)* legitimacy coexisted with low attitudinal commitment

(28: CH) Low moral *(structural)* legitimacy coexisted with low behavioural commitment

(29: CH) Low moral *(consequential)* legitimacy coexisted with low behavioural commitment.

Sub-group: Specialist Service managers

'A lot of nuts have yet to be cracked'

Specialist Service managers conferred **low moral legitimacy**, in its variant form of *procedural legitimacy*. Criticisms were voiced around top management *"going about things in the wrong order,"* and *"not doing enough planning"* before deciding to proceed with the introduction of the CAT clinics. CAT managers were felt to have been placed in an unfair position of facing capacity management problems when *"they had not been fully set up properly,"* and left without adequate staff resources or medical support to attempt to deliver the exit strategy. A common theme was that *"there was a lot of work still to be done."*

"It could have been improved on by having all the staff in place first, and giving them adequate time for planning what they were going to do with the exit strategy."

(Maria, Drug Court, Specialist Service)

"It does feel like we are still at the very early stages of working out how we should be going about things." (Dr. Mary, Obstetrician, Specialist Service)

For example, the NE CAT shared the entrance and reception area with GCC's Children & Families team. The NE CAT Operations Managers' decision to hold methadone clinics in the building meant that many more people were sharing the same reception area than before. Sean, the Children & Families manager, warned top management about the implications of this step six months previous. However, they took little notice of his concerns and sanctioned the use of the NE building to hold CAT clinics regardless.

"I want to create a child friendly environment, where mums on-the-make can come with their children, and not feel intimidated or uncomfortable. We need to deal with the problem of the shared reception area once and for all, as the CAT has now started their clinics in here. It's not that we have hundreds of their punters selling drugs in here, or nipping into the toilets and gouching out[39]. But if we don't deal with this sooner rather than later, my anxiety is that it's only a matter of time before have real problems. I've been saying for some time that we need separate waiting areas. It still bothers me that we have not cracked that particular nut."

(Sean, Children & Families / Criminal Justice, Specialist Service)

'The short-lived effects of top management intervention'

Despite the level of hope that followed top management's intervention at Time 2, Specialist Service managers now expressed **low attitudinal commitment**. Although initially supportive of the edict approach to provide clarity for them, its effectiveness appeared to be short-lived, and their earlier optimism seemed to have dissipated.

The introduction of the Homelessness Interface Protocol had not been very successful in helping CAT managers accept stable transfers from the HAT. John, the HAT manager, believed that it could only be effective if it was applied in a unilateral fashion, but CAT managers had *"not kept their side of the bargain."* The transfer process still proved difficult, as CAT managers were inconsistent in their approach to adapting it, while some were openly dismissive of it. John took the resigned view that *"a lot of it is down to individual will to use it or not".*

"The way we are working is of benefit to the client, but only if every other service is working the same way. We now have the protocol, but the whole thing has not really developed"

(John, HAT, Specialist Service)

John also suggested that there were limitations to top management edicts. Lack of enforcement of the protocol, in terms of top-down communication being followed up by no monitoring, meant that it was never clear to top management if CAT managers actually understood what was now expected of them in dealing with the HATs, or any Specialist Service where edict tactics were employed.

[39] 'Gouching out' is the lethargic incapacitated state that heroin users present with upon having injected intravenously (Royal College of Psychiatrists Factsheet, 2004).

"If you talk to people at the top, you will get the overall strategic view. They have quite a clear and concise view of how things should work. And I think fine, I have got that. You then go back to the CATs and say 'I've spoken to the General Manager and this is the way things are, and this is the way we do it.' They just reply, 'well, that's not our take on this. The manager has not spoken to us.' So, there is still that gap in understanding if you like."

(John, HAT, Specialist Service)

Some managers believed that top management intervention had been *"too little, too late."* For example, nine months after CATs were introduced a member of the top management team gave a presentation explaining how CATs ought to address child protection issues while unveiling the 'CAT-Children & Families Interface'. The response to *"yet another addictions road show"* was one of scepticism, as top management's efforts were now derided by many.

"We now have 'the interface'. I'm not sure the interface message got across or really hit home. But 'the interface'? Och c'mon! We need a better language for all this. It sounds like something from Star Trek." (Sean, Children & Families / Criminal Justice, Specialist Service)

Third-order analysis point

Specialist Service manager's third-order evaluations affected the nature of the L-C relationship in two ways.

On one level, it remained non-reciprocal. For example:

(30: SS) Low moral *(procedural)* legitimacy coexisted with high behavioural commitment.

On another level, the L-C relationship changed to reciprocal. For example:

(31: SS) Low moral *(procedural)* legitimacy coexisted with low attitudinal commitment

(32: SS) Low moral *(consequential)* legitimacy coexisted with low attitudinal commitment

(33: SS) Low moral *(structural)* legitimacy coexisted with low attitudinal commitment

(34: SS) Low pragmatic *(exchange)* legitimacy coexisted with low attitudinal commitment.

Table 5.1 Summary data analysis

Goal 1: Develop an exit strategy for methadone service users

Time	Sub-group	1st order	2nd order	L-C relationship	3rd order	L-C relationship
1	Community Health managers	Ambivalent	High moral *(consequential)* legitimacy Low pragmatic (*exchange*) legitimacy Low attitudinal commitment	Reciprocal & non-reciprocal	Low cognitive *(comprehensibility)* legitimacy Low moral *(procedural)* legitimacy	Reciprocal
2		Disapproving	Low moral (*structural*) legitimacy Low attitudinal commitment	Reciprocal	Low moral (*procedural*) legitimacy Low behavioural commitment	Reciprocal
3		Disapproving	Low moral (*structural* and *consequential*) legitimacy Low attitudinal commitment	Reciprocal	Low moral (*procedural*) legitimacy Low cognitive *(comprehensibility)* legitimacy Low pragmatic (*exchange*) legitimacy Low behavioural commitment	Reciprocal

Table 5.2 Summary data analysis

Goal 1: Develop an exit strategy for methadone service users

Time	Sub-group	1st order	2nd order	L-C relationship	3rd order	L-C relationship
1	Specialist Service managers	Approving	High pragmatic (*exchange*) legitimacy High behavioural commitment	Reciprocal	High cognitive *(comprehensibility)* legitimacy	Reciprocal
2		Ambivalent	Low moral (*consequential* and *structural*) legitimacy Low pragmatic *(exchange)* legitimacy High behavioural commitment	Non-reciprocal	Low cognitive *(comprehensibility)* legitimacy Low moral (*procedural*) legitimacy High attitudinal commitment	Non-reciprocal
3		Ambivalent	Low moral (*consequential* and *structural*) legitimacy Low pragmatic (*exchange*) legitimacy High behavioural commitment	Non-reciprocal	Low moral (*procedural*) legitimacy Low attitudinal commitment	Reciprocal & non-reciprocal

CHAPTER 6 DATA FINDINGS

Strategy Goal 2: To ensure that working in CATs is a professionally rewarding experience

"CAT managers have a key role to play in the development of an exit strategy. A key component of the methadone programme will include allowing clients the time to reflect upon the difficulties posed by their drug use. Nurses and social workers will be able to enhance their skills and experience by helping clients develop coping skills, and help them understand the relationship between their emotions, their behaviour, and their substance use. Providing this type of support, in conjunction with methadone therapy, will ultimately help move service user's on towards full rehabilitation and ensure that working in a CAT will be a professionally rewarding experience." **(Glasgow Addictions Strategy, Jun.03)**

TIME 1 (December 2003)

FIRST-ORDER ANALYSIS

'Managing the numbers game'

The task of developing an exit strategy and managing system throughput more effectively was handed to two middle managers who were promoted on a temporary basis to the position of Operations Managers. The East CAT would be led by 'Joe' who was a social worker and employee of GCC. NE CAT would be led by 'Margaret' who was a nurse and employee of NHSGG. It was now their job to pull together existing addiction services to develop Goal 2, with CATs playing a pivotal role at the centre of this process[40].

"We need to have the door open at both ends. It can't just be about everybody coming in and staying in. It's really about how sophisticated we can be in managing to get folk out of the service as well if this is going to work or not." (Joe, SW, Operations Manager, East CAT)

[40] Several weeks before the two pilot CATs were introduced, a new Joint General Manager was appointed to lead Glasgow's integrated addiction services. The chosen candidate was a highly experienced employee of GCC, who had worked for almost twenty years within the addictions field. It was decided that permanent management arrangements would be formalized over the next six months, as there was no possibility of having a newly-selected joint management team in place by December.03. It was agreed that a temporary management team would be formed for the period December.03 – May.04. The temporary management team consisted of senior and middle managers from GCC Addiction Services, GDPS, and the A&DD. Like other members of the temporary management team, Joe and Margaret were advised to start working across traditional organizational boundaries in partnership with their health or social work colleagues.

As a result of their temporary promotion, Joe and Margaret were co-opted into top management discussions around developing Goal 2 (i.e. 'vertical co-optation'). They had also been encouraged to meet regularly to discuss how they intended to address Goal 2. At Time 1, they were both emphatic about the need to improve the professional development of CAT managers beyond their current *"fire-fighting"* role which they believed was no longer intrinsically rewarding. For this reason, they gave Goal 1 their **approval.**

Other CAT managers were not co-opted upwards, although they were given the responsibility for developing the finer details of the exit strategy at local level (i.e. 'horizontal co-optation). They fully supported their Operation Managers' plans for them as these would help ensure that their involvement in methadone clinics would be more professionally fulfilling than it was previously. CAT managers indicated their **approval** of Joe and Margaret's idea that methadone clinics could work more successfully if nurses and social workers had more time to adopt therapeutic counselling approaches as a way of helping move people on, instead of *"just handing out the scripts"* which was the sum of their experience to date.

SECOND-ORDER ANALYSIS

First-order analysis highlights that CAT manager's level of support towards developing and implementing Goal 2 was unanimous. Time 1 narratives are now analyzed further to examine how levels of acceptance, approval, and adoption were influenced by middle manager's legitimacy and commitment evaluations, and whether the relationship between these evaluations was reciprocal or non-reciprocal.

Example 7: CAT managers ('vertically co-opted')

Joe and Margaret conferred **high moral legitimacy** upon Goal 2, in its variant form of *consequential legitimacy*. They believed that failing to implement an exit strategy would ultimately impact on the retention of their most experienced managers. They resented how nurses and social workers had for too long been required to *"play the number's game,"* and singled out criticism for the GDPS' clinical director ('Dr. Jane') whose approach to managing methadone clinics appeared to have been heavily influenced by the Operations Management module of an MBA course that she had embarked on.

Dr. Jane was accused of being pre-occupied with a systems-based approach to clinic management which conceptualized "*clients as a unit or a number."* This was cited by Joe and Margaret as the main reason why nurses and social workers had become indifferent to how methadone clinics were working. Instead, they promised to ensure that *"a more quality-based approach"* would be adopted within methadone clinics, and both declared that improving the professional development of CAT managers was *"top of their agenda."*

"We need to get the clients out of the clinics for their sakes, but also for ours. The job isn't so great for people when they are just doing the bare minimum with clients because the clinics are jumping." (Joe, SW, Operations Manager, East CAT)

"Up until now, the focus has been on 'get them in, get them out'. The nurses haven't really had the chance to develop professionally. We've not been geared up for that. So we want things to be more scientific, more evidence-based, and to have more multi-skilled staff who can offer a variety of different things. We will make sure that they will have the time to start to develop some meaningful therapeutic relationships with patients to help them move on."
(Margaret, Health, Operations Manager, NE CAT)

Joe and Margaret expressed **high behavioural commitment** to Goal 2. Central to their pledge to develop an exit strategy was to establish the practice of CAT managers conducting regular review and supervision sessions that involved lower-level staff. This process would help to determine how far clients were moving towards full rehabilitation, and help identify those most suitable for discharge from the methadone programme.

Second-order analysis point

At Time 1, the nature of Joe and Margaret's evaluations suggested that the L-C was reciprocal. For example:

(35: VCO[41]) High moral *(consequential)* legitimacy coexisted with high behavioural commitment.

Example 8: CAT managers ('horizontally co-opted')

In response to their Operation Manager's plans, CAT managers conferred **high pragmatic legitimacy** upon Goal 2, in its variant form of *exchange legitimacy*. They all believed that the

[41] 'Vertically co-opted' CAT managers abbreviated to VCO

plans which Joe and Margaret had in mind for developing an exit strategy were going to make their roles more satisfying. For example, former GDPS nurses resented the 15-minute patient contact time-restriction imposed on them by Dr. Jane, their clinical director. They believed that this prevented them from developing stronger therapeutic relationships with their patients. While SW managers, who were involved in supporting Shared Care clinics, were *"frustrated"* that their roles had become unrewarding because of the high volume of clients they were failing to help move on.

"Sometimes you are just doing crisis management with cases, and there is health or social issues that you can't get sorted out. So, you're just constantly putting Elastoplasts on clients' problems. If we can tackle their problems on all fronts, and we are able to see people moving on, then that's a sign that we are making progress." (Angela, SW, East CAT)

"Before, it was all about 'playing the numbers game' and how many people we could get through the service for methadone prescriptions. Hopefully that will change and we will have more time to spend with our patients." (Lorna, Health, NE CAT)

These managers expressed **high behavioural commitment** to Goal 2, as they were prepared to comply with any steps that would make their roles feel more rewarding and help service user's move on. They intended to start and engage their clients in more meaningful therapeutic work, and to encourage lower-level team members to do the same.

Second-order analysis point

At Time 1, the nature of CAT managers' evaluations suggested that the L-C relationship was reciprocal. For example:

(36: HCO[42]) High pragmatic *(exchange)* legitimacy coexisted with high behavioural commitment.

THIRD-ORDER ANALYSIS

The reasoning which underpinned middle manager's legitimacy and commitment evaluations of Goal 1 is now examined on a third-level of analysis. It explores how their evaluations were shaped by umbrella context factors. It explores how their evaluations were shaped by umbrella context factors i.e. clarity of direction, partial control, clarity of roles, ambiguity

[42] 'Horizontally co-opted' CAT managers abbreviated to HCO

over boundaries, issues around autonomy and discretion, co-optation, participation, and the extent that all of these factors had on developing the finer details of the strategy en route[43].

Sub-group: CAT managers ('vertically co-opted')

'When the horse bolts the stable too soon'

At Time 1, Joe and Margaret conferred **low moral legitimacy** upon Goal 2, in its variant form of *procedural legitimacy*. They were apprehensive that not enough planning had preceded the introduction of CATs. Both offered many ideas around how they could achieve Goal 2, but they disclosed that their ideas remained under-developed as CATs were being launched. Furthermore, no guidance on planning or strategy development had been made available to them prior to being vertically co-opted. The level of support given them at the beginning of the process was very informal.

"Things have been planned to some degree. Even without necessarily sitting down and having a formalized plan added on to the original strategy document, we felt that some of the things we will be doing would be more intuitive if anything. I haven't been given any training on how to cope with the strategic change process. I think one of the things which were probably taken into account was that top management in some way saw Margaret and me as quite experienced managers. A lot of the support we have had has not been formal. It's been very much informal." (Joe, SW, Operations Manager, East CAT)

"I've been able to run things past the General Manager and others up above. It's quite informal. I would be a liar to say that there has been any formal process, or a master plan that I've down sat and gone through with the General Manager."

(Margaret, Health, Operations Manager, NE CAT)

Joe and Margaret sounded a note of caution that perhaps promotional activity, communication exercises, and network lunches were all taking place prematurely without internal operational plans having been designed to meet the expectations of partner agencies and their fellow CAT managers. Both were agreeable to networking with partner agency managers to discuss their ideas, but they were not comfortable about doing so. Although they did not voice their concerns publicly, in private they were both feeling very uneasy about engaging in emergent activity in haste and under pressure from top management.

[43] Chapter 8 discusses and elaborates further upon how umbrella context factors appeared to influence strategists' practices en route.

"I am worried that we try and do everything too soon and we promote ourselves too much and the floodgates will open, and we end up with a huge waiting list even before we are up and running properly and fully functional with the sleeves rolled up."

(Margaret, Health, Operations Manager, NE CAT)

"*There is probably an onus on us in that we have that added responsibility to ensure that we come up with a template that can be rolled out for the rest of the city. So, there is a lot of PR work that we are doing to get the service known, but we need to be careful how we go about that and how much work both of us take on."* (Joe, SW, Operations Manager, East CAT)

Joe and Margaret confirmed that they had been participating in confidential discussions with top management colleagues about the possibility of introducing *"alternative prescribing arrangements,"* as a means of preventing the CATs becoming dependent upon those Community Health managers who were unhappy about the status of the GP contract. They were concerned about how an alternative clinic model might impact on CATs. They both believed that *"things were moving too fast,"* and that the emergent aspects of the strategy were overtaking their original sense of direction in terms of where en route decisions were leading them.

"Top management is starting to think about how we can provide other prescribing services, for example, having our own 'on-site' prescribers in 'CAT Clinics,' because there is definitely going to be a gap in service provision. It seems that we are going to take over the running of the GDPS methadone clinics. We will decide who goes into them and who goes out of them, but I would imagine that capacity will be full very quickly."

(Margaret, Health, Operations Manager, NE CAT)

"It feels like the horse has bolted the stable, even before we have thought about what we are doing." (Joe, SW, Operations Manager, East CAT)

'The early warning signs of being vertically co-opted'

Joe and Margaret expressed **low attitudinal commitment** about what level of strategic success they could personally achieve. They were concerned that perhaps too much responsibility was being placed on them by top management. They doubted if they would be able to accommodate the wide range of interests from different partner agencies and professional groups. They questioned their omnipotence and level of control over other

partner agency managers who were critical to making the exit strategy workable. For example, it had become apparent to them that *"the doctors had complete autonomy to prescribe how and when they wanted to."*

"To me, there are too many fingers in too many pies. One week Joe and I have to talk to this person, and the next week somebody else wants in on the discussion. The week after that, we have to talk to someone else. It is very, very confusing."

(Margaret, Health, Operations Manager, NE CAT)

There were also some early signs that developing the finer details of Goal 2 in addition to their routine activities was proving to be challenging on a personal level. The consequence of being vertically co-opted into the strategy process was already proving to be difficult.

"*I'm managing to get on with things at the moment, but you can only spread yourself so far. In the last month, we've had two young children on the caseload dying. One of our clients has just been murdered, so I'm dealing with the staffing and operational issues with all that. Yet, at the same time you're getting asked, 'can you go to this meeting? Can you do this? Can you do that?' Margaret is in the same boat."* (Joe, SW, Operations Manager, East CAT)

<u>Third-order analysis point</u>

Joe and Margaret's third-order evaluations affected the L-C relationship in two ways.

On one level, it remained reciprocal. For example:

(37: VCO) Low moral *(procedural)* legitimacy coexisted with low attitudinal commitment

On another level, the L-C relationship changed to non-reciprocal. For example:

(38: VCO) Low moral *(procedural)* legitimacy coexisted with high behavioural commitment

(39: VCO) High moral *(consequential)* legitimacy coexisted with low attitudinal commitment

Sub-group: CAT managers ('horizontally co-opted')

'We feel vulnerable to the wishes of others already'

CAT managers' conferred **low moral legitimacy** upon Goal 2, in its variant form of

procedural legitimacy. They shared the same concerns as their Operations Managers that not enough plans or formal agreements with partner agencies were in place as CATs were being launched. Some were particularly aggrieved that information on managing capacity had not been forthcoming, and that launching CATs without the full staff compliment in place was *"madness."*

"I don't know how we are going to cope with the numbers that might come from the HAT. That should really be sorted out before we start doing anything else. And of course, there are the GPs. I mean, are they in or are they out?" (Joanna, Health, East CAT)

"I can see things starting to change with Children & Families and Criminal Justice. Clients are originally brought into the service because of child protection issues. But they are now referring cases on to us so we can do some weekly monitoring for them. It's already happening. We are going to get lumbered with a lot of cases that we are not set up to cope with." (Tom, SW, NE CAT)

<u>Third-order analysis point</u>

CAT manager's third-order evaluations changed the L-C relationship to non-reciprocal. For example:

(40: HCO) Low moral *(procedural)* legitimacy coexisted with high behavioural commitment

TIME 2 (May.04)

FIRST ORDER ANALYIS

'Still playing the numbers game, even when the rules of the game have changed'

In early 2004, the responsibility for the overall management of the new CAT clinics was deferred to Joe and Margaret. They soon became frustrated that *"the money issue"* associated with the GP contract was proving disruptive to developing an exit strategy. They had started to identify those stable clients in the former GDPS clinics that could be transferred back to Shared Care, but GPs were found to be *"rigidly sticking to their position,"* and ignored requests to take back individual [stable] clients even with the incentive of the time-limited £350 fee. GPs were seen as uncooperative, and only interested in contributing to the exit strategy on the condition that their long-term financial demands would be met.

Joe and Margaret had become more **ambivalent** about the exit strategy developing, especially as the planned migration of nursing staff into East and NE CATs was not happening as quickly as they had expected[44]. Working with less staff increased the need for *"more fire-fighting tactics"* from CAT managers in order to minimize the compounding side-effects of the GP contract issue.

CAT managers who had been horizontally co-opted **disapproved** of the new clinic model. The CAT clinics were already *"chalk-a-block,"* and seen as *"nothing more than a holding pen"* that failed to serve the purpose of helping move people on. They viewed the CAT clinics as *"a backward step"* because it was now *"taking on all-comers."*

Health managers reacted unfavourably to managing the day-to-day aspects of the CAT clinics, and responded by placing all new clients who were referred to them on a waiting list. Waiting lists had not existed in the former GDPS or Shared Care Scheme prior to Time 1, but they had now appeared for CAT clinics. Nurses were now *"running hither and thither"* to arrange prescriptions. They also no longer had the option of sending stable patients back to Shared Care due to the capping system.

"New patients are being told by their GPs to 'just go down and see the CAT'. The upshot of all this is that we are at bursting point, and we cannot cope." (Lorna, Health, NE CAT)

[44] This was due to the Alcohol & Drug Directorate and Specialist Services such as the HAT being reluctant to release their nurses as it would leave their own services understaffed until posts left vacant were filled.

SW managers recognized that Health managers were increasingly busy with managing the CAT clinics, and that *"things were beginning to get really hectic for them."* However, by establishing waiting lists, Health managers were seen to have *"changed the rules."* SW managers were now experiencing *"the knock-on effects"* of clinic waiting lists. They were frustrated that they could not easily access a methadone prescription for new clients who self-referred to the CATs. These clients were required to wait over two weeks before a nurse assessed their suitability for methadone.

Shared Care clinics remained operational and continued to be supported by SW managers as before, but these clinics could not expand due to the enforcement of the capping system. Furthermore, those clients who were relapsing in Shared Care clinics could not be quickly directed to CAT clinics for more intensive support from Health managers. Instead, they were required to go onto the waiting list, and SW managers were left responsible for their care in the meantime.

"The nurse's emphasis is on getting everyone transferred over from the old GDPS clinics, and not the new people who are coming through the door that we have to deal with. We know they are struggling with their clinics, but it means that we are now starting to struggle too." (Anne, SW, East CAT)

SECOND-ORDER ANALYSIS

Example 9: CAT managers (vertically co-opted)

At Time 2, Joe and Margaret conferred **low moral legitimacy**, in its variant form of *consequential legitimacy*. They both acknowledged that an exit strategy had not been accomplished as yet, and that their team members were not able to carry out the types of therapeutic work in the way that they hoped they would. All strategic activity was directed more towards setting up the CAT clinics, and managing the influx of new referrals, as opposed to focussing on ways to ensure how therapeutic interventions could be introduced in order to help move clients on.

As capacity management problems were worsening instead of improving, Joe and Margaret's strategic orientation appeared to have changed. Operational pressures meant that the professional development of CAT managers had been relegated to a secondary issue. The 'numbers game' had become the main priority for them. Hence, the shift in their priorities

signalled **low behavioural commitment** towards the *"quality-based approach"* that they had espoused at Time 1.

"To be honest, I've not developed the team to the extent that I would have liked to by now. My priorities are elsewhere at the moment. There is still a capacity problem that we need to address first." (Margaret, Health, Operations Manager, NE CAT)

"The reality is that our priority as a team is, first and foremost, about providing a service. In an ideal world, we would have started all the things we wanted to do, but we have had to put these things to the back of the queue. The political agenda makes it difficult for us to do these things." (Joe, SW, Operations Manager, East CAT)

There were signs that Joe and Margaret viewed themselves as somehow competing around which one of them was facing the harder challenge with Goal 2. Joe argued that the East CAT faced more difficult capacity management issues whilst Margaret cited the problems she faced influencing those managers in NE CAT who were employees of GCC.

"The reality is that the plans I had in place for the East CAT have sort of drifted. I think Margaret has been in a better position than us. I don't mean to sound disrespectful to the North East, but their workload is nowhere near as heavy as ours."

(Joe, SW, Operations Manager, East CAT)

"It is difficult coming into a Social Work building and trying to get everyone to go along with doing things the way that they are done in the health service."

(Margaret, Health, Operations Manager, NE CAT)

<u>Second-order analysis point</u>

At Time 2, Joe and Margaret's evaluations suggested that the L-C relationship was reciprocal. For example:

(41: VCO) Low moral *(consequential)* legitimacy coexisted with low behavioural commitment[45].

[45] In theory, this type of relationship, which emphasized the unintended aspects of the strategy, tended to suggest non-acceptance, non-approval, or non-adoption of the strategy. However, the basis of Joe and Margaret's ambivalence is better reflected by the influence of their third-order evaluations which included high cognitive legitimacy, high pragmatic legitimacy, and high attitudinal commitment.

Example 10: CAT managers (horizontally co-opted)

At Time 2, CAT managers conferred **low pragmatic legitimacy** upon Goal 2, in its variant form of *exchange legitimacy*. Not only were they 'fire-fighting' the long-standing capacity problems as they had previously done, but they were now spending much of their time reacting to the problems created as a result of the cap on Shared Care GPs, and top managements' emergent decision to introduce CAT clinics.

The impact of the GP contract had started to have a demoralizing effect on Health managers. GPs could refer into the CATs, but they were not prepared to accept their patients back once stabilized. This left nurses *"getting lumbered with everything going,"* and leaving them "*more stretched than ever before."* Their hopes of being able to carry out any therapeutic counselling work had disappeared. They described feeling de-motivated about working in a CAT, instead of feeling enthused as they done at Time 1.

"Patients are just coming in and getting a script thrown at them. That is not the way it was supposed to be, but there is no time to do anything else." (Joanna, Health, East CAT)

SW manager's narratives highlighted similar themes. They described their roles as less satisfying than before. They were disappointed that they had not experienced any of the benefits that top management espoused during earlier communication exercises. They did not believe that they could "*claim to be offering any sort of counselling service in the clinics."*

"Look at the resources we have. It doesn't equate with what we are expected to cope with. It is affecting workers morale, their enthusiasm, and their energy. The team might be depleted before long if unrealistic demands continue to be made on us." (Jacqueline, SW, NE CAT)

It became evident that the change process was having an emotional impact on CAT managers. Working within an integrated team was not turning out to be as enjoyable as they had hoped. Health managers described how they were *"at the end of their tether"* and *"struggling just to keep on top of things."* Some confessed to *"shedding quite a few tears."*

"Today is probably the worse I have ever felt in my whole life regarding my work. I am normally quite a calm person, but now I just seem to blow up and explode at everyone. I've thought, 'that's it. I've had enough.' I told Joe last night, 'I enjoy my work, but I don't want to be here anymore'. It's hellish. That is it in a nutshell." (Caroline, Health, East CAT)

Health managers found that they were being put under pressure by their SW colleagues to accept Shared Care clients into CAT clinics when they had become unstable. Refusing these requests was proving to be an unpleasant experience for Health managers.

"The problem that they have got is that all their Shared Care clinics are full as well, so they come to us and try and get their clients into our clinics. But we are so thin-on-the-ground that we just cannot cope anymore ourselves, and we have to knock back these cases. It's not helping team relationships. We know ourselves that it's not. But what else are we supposed to do?" (Joanna, Health, East CAT)

SW managers found that *"everybody was getting really stressed out"* due to *"absorbing the problems that were occurring nearly every week."* They described spending a lot of time trying to reassure lower level SW staff who were frustrated that Health managers were reluctant to automatically accept unstable Shared Care clients in CAT clinics.

Common to both Health and SW groups were claims that the change process was affecting them more than it was affecting their counterparts. For example, Health managers argued that they had taken on extra roles in managing the CAT clinics which SW managers had not done. It was nurses, and not social workers, who were carrying the burden of the increasingly heavy workload. They protested that social workers were less affected by the introduction of the CAT clinics. SW managers conceded that this was the case. They acknowledged that the impact of the GP contract upon the number of clients they managed within Shared Care clinics was unchanged. Nevertheless, it was they who were *"doing all the donkey work"* to keep these clinics running, and not the GPs who were now prone *"to taking a back seat in with their clinics."*

CAT managers expressed **low attitudinal commitment** towards Goal 2 as the prospect of an exit strategy being developed in the next six months was *"no sooner on the horizon."* They predicted that the methadone programme was moving towards *"gridlock,"* and that the pressures to cope with new incoming clients would continue to overshadow the intended aim of moving people on. Some warned that *"it was going to take some sort of crisis"* for an exit strategy to be developed at all.

Top management seemed to be *"hell-bent"* on shifting responsibility for the methadone programme onto CATs, regardless of the impact it would have on team members. Joe and

Margaret's emphasis was now on opening up more clinics, but CAT managers did not believe there were sufficient staff resources to do so.

"The more we absorb, the more they will allow us to absorb. If we keep running with not enough staff, we won't be able to operate the service at all." (Shirley, SW, NE CAT)

CAT managers were pessimistic that the GP contract issue was going to be resolved in the near future. Some GPs had disclosed to them that *"they didn't think it was worth it"* to continue prescribing methadone. CAT SW managers had found GPs to be *"unreceptive to taking any kind of ownership for reviewing their patients"* so that they might be discharged from Shared Care. These clinics were expected to *"trundle along without any movement, in or out."* The shortage of prescribers was also expected to exacerbate current problems rather than improve the situation. Overall, the picture looked very bleak to CAT managers.

Second-order analysis point

At Time 2, CAT manager's evaluations suggested that the L-C relationship was reciprocal. For example:

(42: HCO) Low pragmatic *(exchange)* legitimacy coexisted with low attitudinal commitment.

THIRD-ORDER ANALYSIS

Sub-group: CAT manager's (vertically co-opted)

'En route strategizing behind closed doors'

At Time 2, Joe and Margaret conferred **high cognitive legitimacy** upon Goal 2. Both of them talked confidently about the details of the CAT clinic model and its longer-term implications for the exit strategy. They described having *"a very clear understanding"* of how the CAT clinic model should work in practice, and how it would eventually come to form part of an integrated care pathway that would lead clients towards full rehabilitation.

"The way things are developing at the moment is that I would see the nursing element coming in at the start of a client's treatment. Then the longer term pieces of work outwith the CAT clinics will be carried out by social workers, who will eventually move them out to other less specialized community support agencies." (Margaret, Health, Operations Manager, NE CAT)

The tone and content of their narratives suggested that Joe and Margaret were now speaking with a top management 'voice' as opposed to portraying themselves as strong advocates of the middle manager cause in the way they had done at Time 1. For example, despite their earlier criticisms of the former GDPS clinical director's systems-based approach to clinic management, they were now frequently using terms such as *"systems risk"* and *"logistics"* during their Time 2 interviews.

Joe and Margaret stated that they were now part of a 'Clinic Management Group' ('CMG') whose membership included many of the top management team. This group were now actively intervening to ensure the GDPS to CAT clinic transition process was being efficiently managed. However, they also disclosed that the CMG were engaging in discussions around the long-term future of the methadone programme.

They revealed that some top management members viewed the CAT clinic model as *"an opportunity"* to alleviate the financial pressures associated with enhanced services payments. Confidential discussions were now taking place around ways that GPs could be made disposable to the integrated strategy. Despite the fact that contract negotiations were scheduled to take place in the near future, Margaret indicated that a decision had already been taken to proceed with the methadone programme beyond Apr.05 without the involvement of Shared Care GPs, even though these GPs still held hopes of playing a part in the addictions strategy.

But unknown to partner agency and other CAT managers, plans were afoot that would lead to the Shared Care Scheme being scrapped altogether. The implications of such a move meant that CATs would subsume all methadone clients into their own clinics. CATs were going to become responsible for everyone in Glasgow who was on the methadone programme.

"To be honest, I think we are being a wee bit more proactive than waiting to see what happens with the GP contract situation. I know what the new model is. It's confidential, but what the current situation is giving us is the opportunity to restructure how we deliver the methadone programme altogether" (Margaret, Health, Operations Manager, NE CAT)

'Wearing different hats for different parties'

Joe and Margaret spoke of how the effects of being vertically co-opted had presented some conflicting aspects to their middle manager role. For example, they felt unable to reveal publicly the intentions of the CMG regarding Shared Care, and confided that they could no

longer be completely open with their middle manager colleagues about the *"confidential nature"* of ongoing top-level planning discussions. They often found themselves simultaneously seeking the support of their teams to adapt to the ongoing changes with the methadone programme, while simultaneously trying to avoid disclosing what would unfold over the coming months.

"The dilemma we have got is trying to deal with the status quo, while also trying to dispel some of the rumours that are flying about with regards to what may or may not happen. It is difficult for us to second guess what the GPs might do, and to talk about it with the teams."

(Joe, SW, Operations Manager, East CAT)

"I am trying to get the team to be a wee bit more politically aware about what's happening. It does not seem to be going down too well. But what we are doing just now is strictly confidential." (Margaret, Health, Operations Manager, NE CAT)

Being vertically co-opted afforded Margaret less time for reflection on how the strategy was progressing. This meant that she was making sense of strategic issues in public, and this was making her feel uncomfortable.

"It would probably do me good just to sit down and reflect on where I think I'm going with things. It has just been 'full on' so far. Graft, graft, graft..."

(Margaret, Health, Operations Manager, NE CAT)

She found *"no time for planning anything"* and *"everything felt like it had to be done yesterday."* Working across organizational boundaries at the highest level of two parent organizations was at times confusing for her, as she was often given "*different directions, by different individuals, from different organizations."*

"There is a lot more to my job now compared to six months ago. There are more and more demands being made of me. I find myself having to wear a hell of a lot more hats than I used to do, whether it's from the nursing side, or seeing things from the social work side, or from a management perspective. I seem to be collecting and wearing more hats as time goes on."

(Margaret, Health, Operations Manager, NE CAT)

Joe believed he was on *"a huge learning curve,"* and that the brief he and Margaret had been handed had *"spiralled out of control."* He found himself *"working later and later just to get*

a handle on things," and coping with *"the sheer volume of strategic policy documents"* that were sent to him by top management and from other partner agencies.

What proved particularly difficult for him was that, privately, he did not support the decision to move towards the CAT clinic model. Yet, he did not express his views publicly to top management. He thought it best to *"hedge his bets"* in the belief that the GP contract issue might be resolved through time, and that shifting all Shared Care clients on to the care of CATs wouldn't actually materialize.

"[This is off the record, but] my personal view is that I would hate to see a centralized model of care, which is what the CAT model really is. I've always believed that clients' care should be managed in the community as part of Shared Care, so there is a bit of me which is like, 'I'm not sure if this is all for the best or not'." (Joe, SW, Operations Manager, East CAT)

Despite these role conflict issues and ongoing demands from top management, an emerging theme in Joe and Margaret's narratives was that they were both prepared to withstand the pressures that they were under until their temporary contracts were secured on a permanent basis. In effect, they were conferring **high pragmatic legitimacy** upon Goal 2, in its variant form of *exchange legitimacy*. They seemed prepared to tolerate all problems at all costs.

At the end of their Time 2 interviews, both of them were uncharacteristically evasive about how their teams might develop over the coming six months. They gave similar code-like responses as to what personal part they would continue to play in the strategy process.

"Nurses are certainly a wee bit worried about whether there really is a joint agenda for the service. The top positions are being filled with those from a social work background, so the agenda might become dominated by social issues. That's where you need strong nurse leadership to make sure that health matters remain part of our priorities. One way or another, I hope to be sitting in a permanent job the next time I see you, and be much clearer about what where the service is going." (Margaret, Health, Operations Manager, NE CAT)

"The foundations for the East CAT are being put in place just now. There are still gaps in terms of the work needing to be done with partner agencies and developing the team, but I think we just need to wait and see what happens. There is quite a bit of confusion for a lot of the team, but we are in a transition. Let's just wait and see what happens."

(Joe, SW, Operations Manager, East CAT)

'Forever optimistic, even when some greetin' face folk are moanin''

Joe and Margaret were aware that some of their colleagues were not happy with how Goal 2 had developed so far. However, they expressed **high attitudinal commitment** on the basis that all was going to change for the better for CAT members. Although they conceded that Goal 2 had not been implemented as planned, they were hopeful that the introduction of the CAT clinic model would help support the pathway for clients to eventually move on towards full rehabilitation. They attributed their optimism to *"some ideas and plans that were being put in place"* to free up capacity in the clinics.

"I am very happy with the way things are going. Right at this moment we are planning to expand the social workers input into the methadone programme. We've also been having very formal meetings on the logistics of the new clinics. The team might be telling you something different, but we are going to get there." (Margaret, Health, Operations Manager, NE CAT)

"I'm still really positive about what we are trying to do. I know there are some greetin' face folk that are still moanin' that things are not moving fast enough, but we need to be patient and let the other problems sort themselves out." (Joe, SW, Operations Manager, East CAT)

<u>Third-order analysis point</u>

Joe and Margaret's third-order evaluations affected the nature of the L-C relationship in two ways.

On one level, it remained reciprocal. For example:

(43: VCO) High cognitive *(comprehensibility)* legitimacy coexisted with high attitudinal commitment

(44: VCO) High pragmatic *(exchange)* legitimacy coexisted with high attitudinal commitment

On another level, it changed the L-C relationship to non-reciprocal. For example:

(45: VCO) High cognitive *(comprehensibility)* legitimacy coexisted with low behavioural commitment

(46: VCO) High pragmatic *(exchange)* legitimacy coexisted with low behavioural commitment

(47: VCO) Low moral *(consequential)* legitimacy coexisted with high attitudinal commitment

Sub-group: CAT manager's (horizontally co-opted)

'They are trying to force square pegs into round holes'

Horizontally co-opted CAT managers were much less clear about how the new model was supposed to work in practice. They group conferred **low cognitive legitimacy**, as they did not hold the same level of clarity about the direction of Goal 2 as their Operations Managers held. CAT managers made no reference to the Clinic Management Group, or its function, but instead continued to ask how an exit strategy could be achieved if it was not yet known where, or how, client's general medical needs would be met.

"We are nowhere near developing an exit strategy right now. It feels to us, and to our workers on the ground, that top management are trying to force a square peg into a round hole by saying to us, 'this will work, this will work'." (Shirley, SW, NE CAT)

The intended aim of moving clients out of 'unstable clinics' and into 'stable clinics,' was no longer an available option to CAT managers. Clients who had been stabilized by the former GDPS and other Specialist Services, who would have previously been transferred back to Shared Care, were now being moved into CAT clinics that comprised of mostly chaotic and unstable individuals.

It had become difficult for CAT managers to discern who was were ready to move on, and who required more intensive input. At least under the old structure, they argued, it was possible to measure a client's progress based on whether they were treated in the former GDPS, or in Shared Care, where there was *"some kind of path to progress."* This path had now disappeared, and the task of distinguishing the stable versus the unstable was now more difficult than it had been before integration.

'Emergent decisions coming from above, with little guidance for down below'

CAT managers conferred **low moral legitimacy** upon Goal 2, in its variant form of *procedural legitimacy*. They believed that top management had underestimated the full consequences of their decision to shift the management of former GDPS clients over to the management of CATs. Top management were strongly criticized for failing to consider the resource implications of doing so, the impact it might have on CAT managers themselves, and its implications for the exit strategy as a whole. They were also concerned that the clinics

had been introduced with no formal process to review how they were functioning, or if they would be able to serve the purpose of helping move people on.

Most of all, CAT managers objected to how top management, and Joe and Margaret, had decided to proceed with the new model without any consultation with them.

"We've had no consultation about the new CAT clinics, so it seems a bit outwith our hands. I don't feel as if I'm part of the whole thing. I'm part of something that's trying to be set up but it's like 'Kerplunk'. Some of the straws have gone, and yet we're still trying to hold onto all of the marbles!" (Shirley, SW, NE CAT)

Top management's ideas about how the CAT clinics were supposed to support an exit strategy had not been shared. There was a lack of information about the new model, with *"no written guidelines about how the clinics should be managed in order to move people on."*

"I don't think there is enough communication from the top about what is happening. There is a real lack of clarity about a lot of things. I am not sure our concerns are getting relayed to management, or what has been discussed as nothing is getting fed back to us. It is causing everyone to feel a bit annoyed because we don't know what is meant to be happening with the exit strategy." (Joanna, Health, East CAT)

'The strange disappearance of vertically co-opted middle managers'

CAT managers also conferred **low pragmatic legitimacy**, in its variant form of *influence legitimacy*. They described *"no longer feeling in the loop"* about how they ought to develop Goal 2. They had begun to feel that they had little influence or control over how the methadone programme was proceeding, mainly because they were unable to take any action to influence the outcome of the GP contract situation. Several CAT managers took the view that their respective Operations Managers were no longer promoting their team members' interests, but instead pursuing matters to further their own career prospects.

Joe and Margaret were noticed to have become increasingly *"unavailable."* One manager commented how this was *"strange, seeing as they are meant to guide the operational side of things."* There were now fewer opportunities for CAT managers to *"pin them down"* to express their concerns about issues they wanted addressed at top management level. Joe and Margaret's physical detachment from the day-to-day running of their teams appeared to be

tolerated by [horizontally co-opted] CAT managers at Time 2, who stated that they were only prepared to accept this for so long.

"Lots of people are chasing jobs just now, and I keep hearing about meetings that Joe and Margaret attend with top management. I think they are going into these meetings as CAT managers, but with their own agendas as well." (David, SW, East CAT)

'Complying with the task, but for an emotional purpose and not a strategic one'

Despite their concerns about how Goal 2 was developing, CAT managers continued to demonstrate **high behavioural commitment** by continuing to carry out the review and supervision sessions that Joe and Margaret had requested. This task was left unmonitored by both Operations Managers, therefore, CAT managers had considerable autonomy and discretion as to whether these sessions actually took place or not.

It emerged that review and supervision sessions were not serving the purpose they had originally been set up to achieve. Rather than identifying which clients were suitable for moving out of the methadone programme, review and supervision sessions were now predominantly serving an emotionally supportive function, without being linked to the exit strategy process.

"There is a sort of simmering resentment in the team. I'm just fielding a lot of criticism of nurses, and listening to all the sagas and all the stories." (Shirley, SW, NE CAT)

"Supervision is very important. It's more important than ever. I feel it is necessary during this time of turmoil, just to keep your head straight." (Caroline, Health, East CAT)

<u>Third-order analysis point</u>

CAT manager's third-order evaluations affected the nature of the L-C relationship in two ways.

On one level, it remained reciprocal. For example:

(48: VCO) Low cognitive *(comprehensibility)* legitimacy coexisted with low attitudinal commitment

(49: VCO) Low moral *(procedural)* legitimacy coexisted with low attitudinal commitment

(50: VCO) Low pragmatic *(influence)* legitimacy coexisted with low attitudinal commitment

On another level, the L-C relationship changed to non-reciprocal. For example:

(51: VCO) Low cognitive *(comprehensibility)* legitimacy coexisted with high behavioural commitment

(52: VCO) Low moral *(procedural)* legitimacy coexisted with high behavioural commitment

(53: VCO) Low pragmatic *(influence)* legitimacy coexisted with high behavioural commitment

TIME 3 (December.04)

FIRST-ORDER ANALYSIS

'We have created a monster that is managed by a bunch of complete diddies'

As Joe and Margaret was appointed as Operation Managers on a permanent basis in Jul.04, they remained **ambivalent** about the development and implementation of Goal 2. They attributed ongoing problems to *"the knock-on effects of the GP contract,"* and the transition of moving former GDPS clients into CAT clinics.

However, by Nov.04, NE CAT managers were outraged that Margaret had decided to *"jump ship"* when offered the Lead Nurse post as part of the new top management structure which both parent organizations had agreed to establish. Similarly, East CAT managers had become unhappy about Joe's routine absence from the team, as he was giving more attention to wider top-level strategic issues than to local operational matters.

CAT managers **disapproved** of Goal 2, as they believed that capacity management issues under the integrated approach had created more problems for clients and managers alike. Many continued to highlight that there were now waiting lists for methadone treatment which had not existed one year previously, and that the attempt at developing and implementing Goal 2 had unequivocally failed.

The flow of new referrals for methadone therapy had significantly increased[46]. CAT clinics were described as *"chaotic,"* and *"jumping like never before."* The recommended number of clients for each clinic was 16, but all clinics were now running with numbers in excess of 30.

"It has now got to the stage where we are at a serious point with the CATs. We have created this big monster of a service that is managed by a bunch of complete diddies. It would be wonderful if it worked and it was resourced properly, but it is not. We have raised the expectations so high, and now we are at the point where we can no longer meet those expectations." (Shirley, SW, NE CAT)

"To enable the patients to move on, we need to be able to spend time with them to sort out their problems. At the moment, that is not happening, and we're becoming less likely to ever being in a position to do that." (Lorna, Health, NE CAT)

[46] Over the last twelve months, referrals for methadone therapy were estimated to have increased by around 20 - 25%.

By Time 3, the majority of CAT managers reported that they were actively looking for other jobs. They found that their roles had become highly stressful, more unfulfilling than ever before, and offered little prospect of engaging in any meaningful therapeutic work to help their clients to be able to move on. Health managers had become despondent and angry that the methadone programme had *"ended up as such a complete fucking mess,"* and that *"they were the mugs who were left picking up the pieces."* SW manager's doubted whether the merits of an integrated approach were worth pursuing at all as *"their old teams were a lot happier before than they were now."*

SECOND-ORDER ANALYSIS

Example 11: CAT managers (vertically-co-opted)

Similar to their Time 2 evaluations, Joe and Margaret conferred **low moral legitimacy** upon Goal 2, in its variant form of *consequential legitimacy*. Despite CATs having been in operation since Dec.03, there was no evidence available to them that their managers were now able to engage in more therapeutic counselling work to help their clients move on. Their original intention to see CAT managers doing more than 'playing the number's game' had not been accomplished.

Despite poor success to date, Joe and Margaret remained upbeat about the exit strategy eventually being developed. They continued to express **high attitudinal commitment** towards Goal 2, and cited a litany of all things going well with Specialist Services, albeit their narrative accounts were inconsistent with those of Specialist Service managers.

Joe remained hopeful that, now he had been permanently appointed as Operations Manager for East CAT, *"the right steps would now be taken"* to ensure that CAT manager's roles within methadone clinics would begin to develop as he envisaged. Margaret was optimistic that, now she had been appointed as Lead Nurse within the top management structure, *"the nursing agenda was going to move on leaps and bounds,"* and that *"nurses would be doing the types of things that they were supposed to be doing in the clinics."*

<u>Second-order analysis point</u>

At Time 3, Joe and Margaret's evaluations suggested that the L-C relationship was non-reciprocal. For example:

(54: VCO) Low moral *(consequential)* legitimacy coexisted with high attitudinal commitment.

Example 12: CAT managers (horizontally co-opted)

CAT managers continued to confer **low pragmatic legitimacy** upon Goal 2, in its variant form of *exchange legitimacy*. Over the past year, they had found that their roles had become much more administrative, more physically-demanding, and more stressful than ever before. The aspirations which they held at Time 1 had all but dissipated. Working in a CAT was not turning out to be as professionally rewarding in the way that top management had depicted it would be during early communication exercises. By Time 3, CAT managers were deflated, demoralized, and sounding defeated.

Health managers reported that rather than becoming more skilled, and finding that their roles were more fulfilling working in a CAT, they felt the exact opposite. They had given up on the notion of being able to carry out any meaningful therapeutic work with their patients. They no longer believed that they were as competent as clinicians, because the care and management of their patients was now *"out of their control."*

They felt that they had *"let their patients down"* because *"they had allowed their standards to slip,"* and that *"they couldn't keep track any longer of what was going on in their patient's lives."* Some described feeling *"frightened"* that CAT clinics were operating at *"dangerously high levels,"* and that *"it was inevitable something was going to go horribly wrong."*

"I am just not managing to give them the care that I would want. I know that my own standards of care have dropped, and I feel that the chance to do anything more than the basics is way out of the window. At the moment, it is all about tripping up on patient's problems as they appear." (Lorna, Health, NE CAT)

SW managers described similar experiences. They had found that working in a CAT meant that their roles had become much more reactive, as opposed to being more pro-active. It continued to be characterized by crisis management, and the opportunity to plan and discuss with a client their longer-term path towards full rehabilitation was proving impossible.

Both groups continued to re-iterate their views that it was their own professional group, and not their team counterparts, who had deemed to be more responsible for managing the burden of the CAT caseload. SW managers believed that they were *"losing the battle"* against

"getting lumbered with new cases" from their nursing colleagues who had *"closed the doors of the CAT clinics."* While Health managers argued, that "*they could spend the whole day just responding to urine sample requests from social workers, without ever being able to get on with their own work."*

The emotional impact of working in a CAT appeared more distressing for managers at Time 3 than what it had appeared to have been at Time 2. The personal cost of coping with capacity management problems was taking its toll. Many openly expressed their frustration about the situation that they had found themselves in. They were angry that top management expected them to continue to 'fire-fight' problems, but also that they were expected to accommodate additional en route initiatives too (e.g. data collection exercises to monitor service activity). During Time 3 interviews, several were close to tears when describing their experiences. Even though they attempted to *"keep a handle on things,"* their narratives indicated a sense of failure and hopelessness.

"Things are worse than before. I don't know what I think anymore, but I know I am not happy here. I always feel dead depressed after I speak to you about how the process is going. It makes me think about what has really gone on here. It makes me realize how much I now hate my job. I want to get out of here." (Angela, SW, East CAT)

"I am struggling. I need help and I can't get it. I just can't cope anymore."

(Lorna, Health, NE CAT)

"The negative side of what we're trying to do is that I just feel as if things are running away from us. It's as though sometimes my work has become so uncontrollable. I've got a paper trail from here to bloody Sauchiehall Street. I'm not getting a chance to finish one thing without getting asked to do another. The phone just seems to be red hot and I'm like 'oh, for fuck's sake! Leave me alone!' I was never like that before." (Anne, SW, East CAT)

SW managers described feeling inadequate that they were no longer able to address the concerns of lower-level workers. Managing the anxieties of this group had come to dominate these middle manager's everyday routines. The loss of motivation among the lower-level staff group had convinced SW managers that their workers were no longer interested in continuing to develop Goal 2 at all.

"I have to keep people going now on a daily basis. The workers are really unsettled. I don't like people feeling uncomfortable with change, because I feel uncomfortable with change too.

With the amount of change that has gone on, I feel that I should have more answers for my workers, but I don't. I feel like a right idiot." (Shirley, SW, NE CAT)

"I feel as though I'm doing some of my colleagues a disservice because I think I should be more available when I'm not. I feel so overburdened myself. The pressure from the top is just cascading down, and because I'm suffering, the ones I manage are suffering too."
(Anne, SW, East CAT)

CAT managers were now re-appraising their roles as caring professionals altogether. Those who saw working in a CAT as an *"ideal dream job"* at Time 1 took a very different view of this issue by Time 3.

"I used to be able to heal people, but that doesn't happen here. I can't heal anybody, and I can't make anybody better. I find it quite difficult that I have got these patients that are going nowhere because there is no exit strategy in place for them. Nobody is going anywhere, so I have got to the stage that I have done as much as I possibly can for individual clients. I can't do any more." (Sandy, Health, NE CAT)

"We are supposed to be compassionate people in this job, dealing with difficult clients. Whereas now, it just seems like we are always looking for the time and the space to actually do that." (Tom, SW, NE CAT)

The general consensus across both teams was that they expected the current situation to worsen, and they expressed **low attitudinal commitment** towards Goal 2. None of this group held out any hope that an exit strategy could be developed and implemented in the near future, and they had given up any hope of their roles becoming more satisfying and professionally rewarding over the coming six months.

As GPs had predicted, CAT managers now found themselves dealing solely with incoming cases. Subsequently, they had no time to move cases out the other end of the system as they struggled to find the time to complete the detailed administrative procedure of doing so. They did not believe that the GP contract issue was likely to be resolved soon, or that the prospect of an exit strategy remained viable under the status quo.

However, the principal reason why their attitudes had become more cynical and pessimistic was down to the overwhelming degree of resentment that was directed at top management, as well as Joe and Margaret, who were collectively perceived to have *"abandoned"* the East and

NE teams. CAT managers were no longer convinced that their own aspirations for helping clients move on were shared by Joe and Margaret, or that *"the quality-based approach"* was still *"top of their agenda."* The *"goodwill of staff,"* which Joe and Margaret had frequently referred to as a key factor in helping support the methadone programme, now appeared lost. CAT managers maintained that as long as top management and Operations Managers remained *"out of touch with what was actually going on in the teams,"* then an exit strategy was unlikely to ever be developed and implemented.

In the NE team, CAT managers were extremely bitter about Margaret's decision to leave the team after only nine months. The content of their Time 3 narratives conveyed the depth of ill-feeling that Margaret's departure, and the preceding events leading up to it, had left. They believed that *"ambitious Margaret"* had merely used the NE CAT change process as *"a stepping stone"* towards an appointment within the new top management team. The impact of Margaret's *"flying visits,"* and top management having *"no understanding of what was going on in the North East team,"* had left the team *"feeling like shit."*

"Things have just ground to a halt. There are no fresh ideas, and there is no impetus to do anything. We are at a stalemate just now. Something has got to give. Do the big wigs want a quality service or do they want numbers? They need to tell us." (Tom, SW, NE CAT)

The NE team were *"still in the dark"* about whom Margaret's replacement was going be, but whoever it was *"had a hell of a job on their hands to win back the good faith of the team,"* and *"clear up the fucking mess up that 'she' had left behind."* Their outlook towards the future development of Goal 2 was very negative, as *"the expectations of what they were supposed to achieve were still so unrealistic."*

In the East team, CAT managers expected Joe to be *"absent as usual"* over the coming months, even though he had officially been named as the permanent Operations Manager for East CAT. Since the team was formed, Joe had been giving the impression to SW managers that *"he didn't want to know about any of their problems."* However, they began to notice that Joe's management style had changed since his permanent appointment. He was beginning to be more direct and autocratic instead of being "*sweet-talking Joe,"* whose charismatic style was widely-known to be persuasive, and often involved *"a bit of bargaining just to keep everybody happy."*

"I am now just making decisions that require less consultation. So I'm saying, 'well I've heard what you have got to say, but this is what you are going to do'."

(Joe, SW, Operations Manager, East CAT)

Joe had begun confronting team members about the accuracy of their caseload numbers, by scrutinizing and challenging the volume of their workloads. SW managers took a rather dim view of his change of approach towards them. They believed that his new management style was unlikely to motivate or encourage them to contribute towards an exit strategy.

"I think Joe's role has changed. He's not here a lot. I probably need to sit down and talk to him and say, 'where the fuck have you been Joe?' It's me and the other managers that are left to get on with things. I feel like we've been shafted big time." (Anne, SW, East CAT)

"The relationship we have with Joe is totally different now. He's actually a really good guy, but the relationship isn't really there anymore. If things are not getting done the way that he wants them to be done, he has told us that 'heads will roll'." (Angela, SW, East CAT)

Analysis point

At Time 3, CAT manager's evaluations suggested that the L-C relationship was reciprocal. For example:

(55: HCO) Low pragmatic *(exchange)* legitimacy coexisted with low attitudinal commitment

THIRD-ORDER ANALYSIS

Sub-group: CAT managers (vertically co-opted)

'Sweet-talking Joe: the strategist who pulled in the reigns from the start'

At Time 3, Joe conferred **low pragmatic legitimacy** upon Goal 2, in its variant form of *influence legitimacy*. He disclosed that he had intentionally *"held back"* from making concerted efforts to develop and implement the exit strategy. His justification for doing so was that he felt he had little influence over the outcome of the GP contract issue, and that the exit strategy was *"kind of put on the back-burner"* until the future involvement of GPs with the methadone programme was concluded and made final.

As he indicated at Time 2, Joe supported the inclusion of GPs in the strategy process, and wished to see top management maintaining the Shared Care Scheme. However, as an

employee of GCC, he believed that he had no control over the affairs of NHSGG and their negotiations with the BMA. Therefore, in the meantime, he decided it prudent to remain a spectator to the *"political game of poker that was being played out with the Health Board and the GPs."* He thought it better *"just to keep his head down,"* as the best means to securing his own permanent position rather than getting involved in the public debate over *"the rights and wrongs of what the GPs were up to*."

Joe's actions during the last year indicated **low behavioural commitment** towards Goal 2. Until his temporary position as East CAT Operations Managers was officially made permanent prior to Time 3, he was reluctant to fully commit to Goal 2. Like other members of the temporary management structure, he risked being moved to another part of the city only to be replaced in the East CAT by somebody else. Therefore, until his own future was secured, he decided not to be proactive in addressing Goal 2 issues.

"*I was very conscious from the word go that it needed to be a slowly managed process. I have to say that there was a bit of me that held back, partly because I wanted to see what would happen to me. Initially, there were ongoing issues that folk might be getting moved about and all that kind of stuff. So, for me, it was a case of you could invest a lot of time and you could put a lot of work into the team, but at the same time you're like 'well I don't know if things are going to remain as they are? Is everything going to change for me? Will I still be here? I can set everything up here then just get moved on'. That was in the back of my mind to be honest."* (Joe, SW, Operations Manager, East CAT)

Joe referred to how he saw his temporary job description as *"more or less a blank canvas"* that allowed him the scope to decide if he should start engaging in strategic activity across organizational boundaries, or how much attention he would give to developing the finer details on the exit strategy internally. His disclosure was corroborated by other managers with whom he had confided, or colluded, that he was *"just going to pull in the reigns a wee bit."*

"I suppose Joe and I are sort of autonomous out here. We saw that things were not going according to plan with the GPs. We could have done some more formal PR stuff, and we're quite aware that we've not done that. It was deliberate. If we went and advertised the service too much, then even more referrals would be coming in and we wouldn't be able to manage or provide the level of service that we said we would. Plus, existing services had to be maintained and staff were still changing over. We saw that would delay us. So we had to do things in a way that we thought was best, if that makes any sense." (Paul, Health, East CAT)

"There has been a change in Joe's approach lately. He was in an awkward place when he was only temporary because he wasn't sure which way things were going. That put him in a difficult position. Once his job was confirmed, he was able to be clearer about how the team would work." (Linda, Children & Families / Criminal Justice, Specialist Services)

Joe described withstanding the pressure from members of his own team to proceed with developing the finer details of the exit strategy, by referring to external organizational and political issues as justification for holding back. He portrayed himself as acting paternally, in addition to using game analogies to explain to the East CAT the reason for his restrained approach.

"Folk were getting impatient and saying, 'we need to move on this.' But I've been trying to say to the team, 'look, it's like a game of chess. You have got to take your time to make your move. This is a transition, and there has got to be a bit of manoeuvring. We are dealing with different personalities, politics, and different organizations. I might be slow on this, but trust me. Let's try and get some of the fundamentals right'. Some of the reasons for holding back were done in the best interests for the team. They were done with good intentions."

(Joe, SW, Operations Manager, East CAT)

He faced similar pressures from top management to actively address capacity management issues. As he put it, *"he was playing a bit of a juggling act"* by saying internally to his team that he was *"sorting things out externally to make things better for the team in the long-term."* While externally, he was saying to top management he needed to attend to internal team issues before responding to their requests.

"To be honest I did fend off a lot of things. I was getting emails from above saying 'this information hasn't been returned to us' or 'where are the stats?' I'm saying, 'look, this stuff hasn't been returned because I'm trying to get things going with the team. I appreciate you need it' and all that stuff. Whereas with the team, I said to them that 'they would just need to wait for some things to happen. I'll take the hit on the chin first, and then eventually we can roll things out when we are ready'." (Joe, SW, Operations Manager, East CAT)

'Ambitious Margaret: the strategist who pulled up, and put on her nurses hat again'

Margaret also conferred **low pragmatic legitimacy** upon Goal 2, in its two variant forms of *influence* and *exchange legitimacy*. This was based on her personal experience of being

undermined by her SW colleagues at middle and lower levels, whom she described as making life difficult for her to the extent that she was unable to influence or control them in any way. She cited three incidents of note.

First, lower-level SW staff had reported to Margaret that they were no longer receiving supervision from SW managers, and that *"they were not getting 'the OK' to shut cases"* on their caseloads. Margaret confronted SW managers with the matter. They responded angrily, and were *"greatly offended"* by the suggestion that they were not carrying out supervision.

When Margaret attempted to address the issue through GCC's social work line management structure, she found little support or guidance about how to proceed with the matter. She felt that she was no longer able to enforce review and supervision process, as she had little influence over those SW managers who belonged to a different organization. She had become highly reticent about *"rocking the boat"* or taking direct action to ensure review and supervision sessions were taking place to facilitate the exit strategy.

"I suppose that I do have the authority to sort out the problems, but it is difficult for me to get a real grip on this because I don't want to (pause)....it is crossing that boundary, and still being able to keep relationships good. If I start going over the social work managers' heads, it causes a strain in relationships. I don't want to be falling out with them."

(Margaret, Health, Operations Manager, NE CAT)

Margaret had become increasingly frustrated at SW managers apparent lack of co-operation to develop the exit strategy. She suspected that some were not even attempting to proactively identify clients who were suitable to move on to full rehabilitation. Her appeals for co-operation at team meetings were met with silence.

"People are now saying to me, 'I don't know what you are talking about' when I ask them about getting people moving on. I can't understand it, because they all sit there at the team meeting nodding saying 'Aye, we will help out, we understand.' I mean, you need to say the words, 'Do you understand what I'm trying to achieve here?' and everybody is sitting nodding their head. I started to ask them, 'Come on, do I need to spoon feed you here?' It is almost as if they are digging their heels in. They don't really want to be involved anymore."

(Margaret, Health, Operations Manager, NE CAT)

She discovered that SW managers and lower-level staff had become increasingly risk-averse and reluctant to move clients on in the event of a critical incident occurring. They were

concerned about *"the shit hitting the fan"* if anything untoward happened to their clients following their discharge from NE CAT. Margaret noticed that they had begun openly talking about *"litigation and legal stuff,"* as justification for not moving people on.

Second, in exchange for her efforts to develop Goal 2, Margaret felt that her managerial reputation was being compromised by continuing to work in NE CAT, as there was little scope for experimentation as part of the emergent process. If some ideas were tried out and failed, team members reacted unkindly towards her. When her new ideas had not borne fruit, these were being publicized outwith the NE CAT, and finding their way up to top management level where she was now being confronted about the NE CAT *"being a mess."* Over time, she could no longer contain this problem. Consequently, she had gradually become less likely to make recommendations to her CAT managerial colleagues about developing the finer details of Goal 2, for fear that poor success would receive *"even more bad publicity."*

"As soon as something is not working well, everybody and their dog seem to know about it. When I started to hear from the General Manager that 'it was a mess in NE CAT,' I was kind of shocked. I didn't say anything at first. I found out that one of my social work managers was going around saying 'it was a mess up here'. I had to confront him with it and say, 'look, we can't work up our problems into a frenzy by going around saying 'everything is a mess'. That is insulting. It's not a mess, but what can I do?"

(Margaret, Health, Operations Manager, NE CAT)

Third, Margaret suspected that her incoming calls to the NE CAT were being withheld, or diverted away from her, by GCC administration staff. She found herself *"getting pulled up"* by members of the top management team for being unavailable, or non-contactable, on specific dates and times when was in her office working. She was aware of partner agency managers commenting that *"Margaret's phone always seems to ring out, and you can never get a hold of her."* She was upset that these types of comments had become all too frequent, and conscious that she gaining a reputation as someone who was difficult to contact. However, she had no control over the management of GCC administration staff, and remained unable to formally address the problem.

Eventually, Margaret decided that she was *"fighting a bit of a lost cause."* She began actively looking to leave the NE team by applying for, and subsequently accepting, the position of Lead Nurse with the new top management structure. Margaret had effectively signalled **low**

behavioural commitment not to continuing with, nor seeing out, the development and implementation of Goal 2.

NE CAT manager's narratives suggested that Margaret had already made it her intention to leave the team as far back as Time 2.

"We always knew that Margaret was leaving soon after she just got here. She was never shy about it. She is very career-minded and always has been. It makes sense now, with the way she operated. She made if half-way through the first year, and then said to us at a meeting, 'If I get the opportunity to hold the Lead Nurse post, I am going for it. That is where I want to be.' It had a knock-on effect, so people felt she was never really going to be here for that long, and that any changes she wanted implemented would only be to further her own career. You're not going to put a lot of effort into something and work for a line manager who isn't going to be here for long." (Shirley, SW, NE CAT)

'Reflections on how the race was run'

Joe and Margaret conferred **low moral legitimacy**, in its variant form of *procedural legitimacy*, albeit, they held slightly different views on the umbrella process.

Margaret wished that more formal planning was undertaken at the start of the strategy process, instead of en route emergent activity determining its direction. There had been no consistent message from top management about how to go about implementing the exit strategy, but the emphasis that was placed on emergent strategizing had failed because *"there were just too many people involved with different ideas and different agendas."*

She argued that there should have been more top-level guidance and direction from the start of the process to help develop the finer details around the exit strategy. The broad principles on their own were not enough, especially as these were not accompanied by *"a clear map or a plan"* from which to make reference to on her journey. If there had been she argued, *"things would have turned out differently."*

"In an ideal world, it would have been nice knowing the direction that we were supposed to be going in, and what the priorities were. Life would have been a helluva lot more simple. So, if I could turn the clock back, I wouldn't say I'd have slowed things down, but I would maybe have tried to prioritize the workload right back at the beginning. What were we to achieve in first three months, or second three months? Everyone who was going to be involved should have been taken away to make sure we were all singing from the same hymn sheet, and to say

'look, this is what the priorities are. Are you in, or are you out?'"

(Margaret, Health, Operations Manager, NE CAT)

Joe placed less emphasis on the lack of planning that Margaret had done. Instead, he focused more on the level of expectation that top management had created at the start of the process, which he believed could never have been met during the first year of the integrated strategy.

"My take on all this at the beginning was that we shouldn't run before we can walk. It's not as if we had a magic wand that put everybody in place from the start, whether it was the new management team, or the frontline staff that we needed to run the clinics. We were never really allowed the time to stand back and think about some of the fundamental stuff that we should have thought about first." (Joe, SW, Operations Manager, East CAT)

Joe argued that Goal 2 had not been accomplished because other unplanned issues took precedence over his original intention to see CAT managers doing more than 'playing the number's game'. He maintained that it was competing agendas and *"different political priorities"* that sidelined what top management espoused when CATs were introduced, and not purely down to the lack of more detailed and robust formal planning.

"The worry that I had, was that a lot of the planning that was originally put in place was just thrown up in the air. It was almost like, 'we've got to run on this, and now we've got to drop that'. It was a Catch-22 scenario. We were treading a mine-field a wee bit. We found ourselves trying to balance the introduction of the CAT clinics with the Shared Care Scheme still operational. Then there was the whole political agenda going on behind the scenes about what we could do next, so things were changing all the time. That's what really affected us more than anything." (Joe, SW, Operations Manager, East CAT)

'Ambivalent strategists, who maintain the integrated strategy was the right way to go'

Although they had conferred low moral legitimacy in its variant form of *[low] consequential legitimacy*, Joe and Margaret also conferred **high moral legitimacy** upon Goal 2 in its variant form of *[high] consequential legitimacy*.

Even though the retention of CAT managers was now considered to be in jeopardy, and that both teams had not succeeded in applying a therapeutic-counselling approach to help clients move on and instead continued to 'play the number's game', Joe and Margaret emphasized that the integrated approach to developing an exit strategy was still worth pursuing for the benefit of service users, even if it was less so for CAT managers.

"We still have the cultural baggage that people bring with them. There are many cultural differences within the North East team. Don't get me wrong, there is some really good work that goes on, although my perception is that we have quite a bit of work still to do. But the world of addiction does look different. We are sharing more information with each other now. So even though we have struggled, I don't think we should go back to the way things were before because the patients would be far worse off if nurses and social workers still didn't speak to each other, or didn't work in the same building. The integrated approach was undoubtedly the right strategy." (Margaret, Health, Operations Manager, NE CAT)

"I'm not naive enough to say that there is an element of disquiet in the East CAT, and I wouldn't dispute that there are still teething problems here. But compared to a year ago, it's like night and day. Hugely better. Every time I see a fatal accident enquiry, whether it's about child protection or adult care, they always come up with the same findings. 'Poor communication, poor partnership working, no integration etc.' How many times do you need to write the same report with somebody else's tragedy attached to it? I would choose the integrated approach if it prevents us reading about the same problems between Health and Social Work, and if it prevents us from letting clients and their families down."

(Joe, SW, Operations Manager, East CAT)

Third-order analysis point [revise]

Joe and Margaret's third-order evaluations affected the nature of the L-C relationship in two ways.

On one level, it remained non- reciprocal. For example:

(56: VCO) Low pragmatic *(influence)* legitimacy coexisted with high attitudinal commitment

(57: VCO) Low pragmatic *(exchange)* legitimacy coexisted with high attitudinal commitment

(58: VCO) Low moral *(procedural)* legitimacy coexisted with high attitudinal commitment

(59: VCO) High moral *(consequential)* legitimacy coexisted with low behavioural commitment

On another level, it changed the L-C relationship to reciprocal. For example:

(60: VCO) Low pragmatic *(influence)* legitimacy coexisted with low behavioural commitment

(61: VCO) Low pragmatic *(exchange)* legitimacy coexisted with low behavioural commitment

(62: VCO) Low moral *(procedural)* legitimacy coexisted with low behavioural commitment

(63: VCO) Low moral *(consequential)* legitimacy coexisted with low behavioural commitment

(64: VCO) High moral *(consequential)* legitimacy coexisted with high attitudinal commitment

Sub-group: CAT managers (horizontally co-opted)

'The mystery of the CAT exit strategy'

The expectation of top management that CAT managers would eventually be able to grasp how the methadone programme's capacity management problems might improve remained vague to many. CAT managers continued to confer **low cognitive legitimacy** to Goal 2, as they continued to ask questions about how the exit strategy was supposed to be achieved. They did not hold the same clear understanding of the exit process in comparison to Joe and Margaret.

CAT managers were no longer sure what top management expected to achieve by operating CAT clinics without the inclusion of GPs. There remained no clear sense of how the CAT clinic model was supposed to work if GPs in Shared Care were not involved in the exit process.

"It's all a bit ambiguous for me. I just feel out of touch with what is supposed to happen. No one has told us how the exit strategy is supposed to come about. I know there is a lot happening behind the scenes, but we've not begun to see any benefit from the CAT clinics, or how it is all going to fit altogether. It's all a bit of mystery really." (Anne, SW, East CAT)

'The illusion of en route strategizing'

CAT managers conferred **low moral legitimacy**, in its variant form of *procedural legitimacy*.

They remained angry that no clarity or guidance was ever offered to them around how the teams were supposed to develop the exit strategy in tandem with the GDPS to CAT clinic transition. Top management were accused of misjudging the time and scope that CAT managers would have to develop the finer details of Goal 2, as CAT managers were now faced with new kinds of capacity management problems that had emerged as a result of the en route decision to introduce the new clinic model.

The disruption of introducing the CAT clinics left this group of middle managers condemning top management as *"naive"* and *"unrealistic"* about the level of en route strategizing activity that could be conducted in light of new unplanned challenges.

"*There is a kind of illusion that we should all be sitting down and talking and discussing developments, and thinking more laterally about the exit strategy. While at the same time there is a queue at the door with clients who we need to problem-solve things for. Before the CATs, we would have planning meetings and then bring in the lower-level workers to share with them what we had decided. We don't have the time to do any of that now."*

(Shirley, SW, NE CAT)

"In reality, we are just floating about without any leadership as such. We are just doing it as it comes, and dealing with the chaos as it arrives at the door. It's having an impact on how we are able to even begin thinking about an exit strategy." (David, SW, East CAT)

'Managers begin to walk away from the numbers game'

CAT manager's signalled **low behavioural commitment** to Goal 2 on four levels. First, the review and supervision process was no longer being carried out during the last six months. CAT managers had become reluctant to continue to promote the principles of the exit strategy to lower level staff. They appeared to be distancing and disassociating themselves from what was perceived to be *"the latest fad coming from the high heid yins."*

This key element of the exit strategy had become relegated to down the list of priorities in the eyes of Health managers. Working in an integrated team had made it more difficult for them to maintain and carry out supervision, in comparison to their experience of working in a nurse-only team. Now, it was more a case of *"the odd informal chat about how things were going,"* as opposed to meeting formally on arranged dates to discuss patients progress, and to identify those most suitable for moving towards full rehabilitation.

SW managers described how recent attempts to keep lower-level workers focused on identifying clients to move on was proving *"nigh impossible."* These workers appeared to be abstaining from participating in review and supervision sessions altogether. They could no longer be persuaded to honour their review and supervision meeting dates. Furthermore, when SW managers sought feedback about Goal 2 from their workers, they received no response. Eventually, SW managers gave up on trying to motivate or encourage them to remain engaged in the exit strategy process.

"If you go into their room to suggest something and ask 'what do you think about x, y, and z?' there is very little response, because they are just thinking 'but where are we going with all this?' Even the more conscientious workers are now saying to me that they are reluctant to implement changes. They're telling me that they just don't bother doing what they are asked to do for a week or two, as things will change again in couple of week's time anyway."
(Shirley, SW, NE CAT)

Second, low staffing levels were compounded by high sickness rates, and coincided with the *"morale of the North East team sinking into its boots."* The offices of the NE CAT were described as now resembling *"the Marie Celeste,"* as fewer members of staff seemed to be around.

"The situation is making people really feel pissed off. There had to come a point where Margaret needed to say, 'I must talk up for my staff here.' But she was 'on tour' for so much of the time, that the team has just become really de-motivated now." (Tom, SW, NE CAT)

Higher levels of absenteeism in the East CAT were attributed to *"people feeling like they were constantly getting their arses kicked from up top."* Health managers in particular described having become mentally and physically fatigued by the pressures that they found themselves under.

"I've never had a sickness record to speak of all the time I've been nursing. Whereas now, I need to take time off. On the Friday, I'm exhausted, and come the Monday, I dread having to go in at all." (Caroline, Health, East CAT)

Third, in Margaret's absence, Health managers in NE CAT took the decision to *"close the doors"* of CAT clinics. They were no longer accepting any referrals for CAT clinics. All new referrals were automatically placed on a waiting list. Health managers were unperturbed by the professional repercussions of this action. In their view, non-compliance was the only

option available to them in order that top management would acknowledge the pressures that they were working under.

"Margaret is never here to ask for advice. She doesn't seem to have time to spend with people. So now that things have got so bad, we decided to say, 'no, enough is enough. That is it. Just shut the door'." (Lorna, Health, NE CAT)

SW managers in East CAT also decided to take direct non-compliant action. They were no longer prepared to release lower-level staff to help support CAT clinics, as they believed that the burden of responsibility for supporting Goal 2 was being too heavily placed upon social workers.

"Joe wants to open another four CAT clinics, but I'm not going to do this until we have got things running more smoothly. I just told him that we don't have the four extra staff we need to do this. I'm not going to start releasing social work staff to CAT clinics when the referrals are still firing through the door, and top management are still hitting us with waiting time demands." (David, SW, East CAT)

Fourth, at the end of their Time 3 interviews, the majority of CAT managers disclosed that they were looking for other jobs outside of their respective CATs. These managers no longer wished to participate in the emergent aspect of the strategy process, co-opted or not. They were angry that top management seemed to take the position that *"the show must go on,"* regardless of the numerous problems that the teams had encountered.

"I find that one year on, people are now chasing other jobs and wanting to get the fuck out of here. The situation has made a lot of folk look at what their next move is going to be." (David, SW, East CAT)

"It's got to the stage that things have gone back the way. It makes me feel compelled to move on and work elsewhere." (Tom, SW, NE CAT)

"I no longer want to be here. Too much has happened. I've got a way out. I've got other options and I've already started marking out my move to another job. If you came back in six months again, I wouldn't be here. I'd be well gone." (Caroline, Health, East CAT)

"Something has got to be done. I am not in a position of power to do anything, to move anything on. I feel pretty helpless. I have done as much work as I can do with these patients. I feel they need to move on, and I need to move on." (Sandy, Health, NE CAT)

'Ambivalent strategists who are not committed, but still believe the integrated strategy was the right way to go'

Despite citing numerous problems with their attempts at developing and implementing the exit strategy, and disclosing their intentions to walk away from the strategy process, CAT manager's conferred **high moral legitimacy** upon Goal 2, in its variant form of *consequential legitimacy*. This evaluation was prevalent across all members of the horizontally co-opted CAT managerial group.

The content of their narratives appeared conflictual and contradictory. For example, their own experiences of change were overwhelmingly negative, yet they argued that the integrated approach towards developing an exit strategy was still "*the right way to go."* They maintained that Goal 2 was worth pursuing due to the long-term benefits to clients, despite all the current problems that it posed for middle managers.

The general view was that, 'if we go about this in a different way to what we have done over the past year, it is the right way to go, because the potential benefits to clients outweigh the negatives for us as managers'.

"I would probably choose the way things are now. But we need to be better resourced. Top management need to come down here and see what we are trying to do with what we have got. You can put as many people on methadone as you like, but at the end of the day, if we don't spend time with our patients, they won't move on." (Lorna, Health, NE CAT)

"We have not had any form of stable management to help roll this out. Our own roles and remit has been so varied, that we have taken on many more problems that we have to deal with. It is impossible to do. We are all quite confused, tired, stressed, and demotivated. We don't know what is happening from one month to the next. There have been no positives for managers, but there have been some positives for clients, which is what we are about and why we are here." (Shirley, SW, NE CAT)

"As nurses, we are still 'the visitors' in the building. We are an appendage...a special perk of the service that is provided. I have been bursting a gut, while some social workers don't seem to be doing anything. Methadone is a controlled drug that needs to be properly managed. To them, the methadone script is just a piece of paper, and it's not. We are the ones responsible for its administration. But things were worse a year ago. What we have tried to do is better

for the patients. It will be better. It just needs worked on. I think 'the real plan' needs to be put in place so everybody knows where they are." (Caroline, Health, East CAT)

CAT managers highlighted the proximity benefits that working together had produced for clients. By having nurses and social workers co-located in the same building, they were able to complete simple operational tasks much quicker than before, and it was the clients who benefited from this.

"There are signs that by working together, we could move people on. Some things have got better, but these are mainly for the patients. There is a lot of stress within the North East team. But things are a lot better because before CATs were introduced we would spend a week or so trying to get a phone call returned from Social Work, and the patients were kept hanging on waiting for things to get done for them." (Sandy, Health, NE CAT)

"The fact that the nurses are in the same building has made some things a lot easier. I can see how it is all 'meant' to work. I was really keen on the exit strategy, and I still am. I would still like to see it working for the clients. I just can't see how it could work for us if we don't have any guidance. We are still running about doing things ad hoc." (David, SW, East CAT)

"There are still lots of problems, and a lot of things we need to overcome. I would still opt for CATs, and for nurses and social workers to be in this together. Things are definitely better because we are in the same environment, and I have got a better understanding of what Social Work do. When I think of the times when we have worked together well, it is the patients who benefit." (Joanna, Health, East CAT)

"Even though Social Work staff have to pick up all the shite, we are nearer each other and trying to do things for the clients that we couldn't do before. If it is done right, I would still choose the integrated approach." (Angela, SW, East CAT)

The recurrent theme which ran through all CAT managers' narratives was that they could see *"the potential"* of what Goal 2 could achieve for clients, and therefore, it was still worth pursuing. However, it could only be achieved with more planning and better scheduling.

"We were all up for it. I welcomed the integrated approach. We all did. I think it has just been rushed though. We needed more direction from up above to make it work. The strategy got off to a bad start to tell you the truth. There was no real preparation for it. We shouldn't have started up until we were ready. We gave the impression that we would accept all the

methadone clients. 'Send us all your poor and needy'. But we have made some better links with each other. We've done some joint assessments, and we tend to rake in some favours from each other that save the clients a lot of waiting about for things to happen. I still believe the integrated approach was right. I really do. I just think it has been rushed, and it has led us into this turmoil." (Tom, SW, NE CAT)

"We never got a chance to gel with our colleagues. We just ran with things. But I would choose what we are trying to do now. Even before the CATs, this place was a shambles. I mean, our previous way of working was all a bit chaotic. So the integrated approach works better in some ways. You can see what it could achieve if we sorted out a lot of the things that we never sat down and planned properly." (Anne, SW, East CAT)

"I would opt for what we are trying to do now. If it's done properly, the outcomes for patients are going to be better." (Paul, Health, East CAT)

<u>Third-order analysis point</u>

CAT manager's third-order evaluations affected the nature of the L-C relationship in two ways.

On one level, it remained reciprocal. For example:

(65: HCO) Low cognitive *(comprehensibility)* legitimacy coexisted with low behavioural commitment

(66: HCO) Low moral *(procedural)* legitimacy coexisted with low behavioural commitment

(67: HCO) Low cognitive *(comprehensibility)* legitimacy coexisted with low attitudinal commitment

(68: HCO) Low pragmatic *(exchange)* legitimacy coexisted with low behavioural commitment

On another level, it changed the L-C relationship to non-reciprocal. For example:

(69: HCO) High moral *(consequential)* legitimacy coexisted with low behavioural commitment

(70: HCO) High moral *(consequential)* legitimacy coexisted with low attitudinal commitment

Table 6.1 Summary data analysis

Goal 2: To ensure that working in CATs is a professionally rewarding experience

Time	Sub-group	1st order	2nd order	L-C relationship	3rd order	L-C relationship
1	CAT managers ('vertically co-opted')	Approving	High moral (*consequential*) legitimacy High behavioural commitment	Reciprocal	Low moral (*procedural*) legitimacy Low attitudinal commitment	Reciprocal & Non-reciprocal
2		Ambivalence	Low moral (*consequential*) legitimacy Low behavioural commitment	Reciprocal	High cognitive legitimacy High pragmatic (*exchange*) legitimacy High attitudinal commitment	Reciprocal & Non-reciprocal
3		Ambivalent	Low moral (*consequential*) legitimacy High attitudinal commitment	Non-reciprocal	Low pragmatic (*influence* and *exchange*) legitimacy Low moral (*procedural*) legitimacy Low behavioural commitment High moral (*consequential*) legitimacy	Reciprocal & Non-reciprocal

Table 6.2 Summary data analysis

Goal 2: To ensure that working in CATs is a professionally rewarding experience

Time	Sub-group	1st order	2nd order	L-C relationship	3rd order	L-C relationship
1	CAT managers ('horizontally co-opted')	Approving	High pragmatic (*exchange*) legitimacy High behavioural commitment	Reciprocal	Low moral (*procedural*) legitimacy	Non-reciprocal
2		Disapproving	Low pragmatic (*exchange*) legitimacy Low attitudinal commitment	Reciprocal	Low cognitive legitimacy Low moral (*procedural*) legitimacy Low pragmatic (*influence*) legitimacy High behavioural commitment	Reciprocal & Non-reciprocal
3		Disapproving	Low pragmatic (*exchange*) legitimacy Low attitudinal commitment	Reciprocal	Low cognitive legitimacy Low moral (*procedural*) legitimacy Low behavioural commitment High moral (*consequential*) legitimacy	Reciprocal & Non-reciprocal

CHAPTER 7 DATA FINDINGS

Strategy Goal 3: Provide equitable and improved access to alcohol services

"It is our intention to improve existing alcohol services to the community by reducing organizational boundaries which individuals have in the past been required to cross in order to receive help. We want to ensure that those individuals with the greatest need have access to the most co-ordinated services possible. To achieve this, we will establish CATs as the single point of entry for alcohol support to ensure equitable and improved access for service users." **(Glasgow Addictions Strategy, Jun.03)**

TIME 1 (December 2003)

FIRST-ORDER ANALYSIS

'Glasgow, the divided city: where no uniformity exists for alcohol services'

Health and social work services were structured by geographical sector i.e. North, South, East and West. This resulted in the emergence of local operational policies and variations in service provision across parts of the city, and was a particular problem for alcohol services. Accessing help for alcohol service users via NHSGG's Alcohol & Drug Directorate ('A&DD') had become increasingly difficult for Community Health, Specialist Service, and SW managers. CAT managers agreed that the level of service alcohol clients received was determined by the *"postcode lottery"* effect that had emerged as a consequence of citywide variations.

"I defy anybody to say that there is uniformity across the city. If you visit the South and West, you would get different approaches in the East and North."

(Joe, SW, Operations Manager, East CAT)

The A&DD's policy in the in the South and West of the city enabled GPs to refer their patients directly by telephone to local teams of Registered Mental Nurses ('RMN's)[47], and to arrange for their patients to receive home-based alcohol detoxification treatment[48] within two

[47] Registered Mental Nurses is the formal title of psychiatric nurses

[48] Detoxification for alcohol involves patients being dispensed anxiolytic medication three times daily to alleviate the physical symptoms of alcohol withdrawal. It requires the patient's blood pressure to be taken, and

weeks. In contrast, GPs in the East and North reported that their patients required waiting up to nine months before being assessed by the A&DD's psychiatrists and psychologists whose waiting lists were *"astronomical."*

"Hopefully, CATs can do what the Alcohol & Drug Directorate in this side of the city should have been doing, and with more urgency. I'd like to organize an alcohol detox and get the patients assessed daily by a psychiatric nurse, who can then connect them up with Glasgow Council for Alcohol for some maintenance support. If we could have in the East what our GP colleagues get in the South that would be ideal." (Dr. Gerry, GP, Community Health)

An additional problem with alcohol service provision was the function of the misleadingly titled Alcohol *and* Drug Directorate. This service had gradually become viewed as "*alcohol-orientated,*" while GCC's [former] Addiction Teams had come to be perceived as having evolved into a predominantly *"drug-orientated"* service as the vast majority of its client group were intravenous (IV) drug users. This perception was wilfully reinforced by Hospital Health managers from the A&DD, who claimed that their remit was "*solely alcohol*" because "*Social Work dealt with the drugs side of things*."

"The Alcohol & Drug Directorate perceives itself to be an 'Alcohol' Directorate, not an Alcohol 'and' Drug Directorate. That is where it sees the focus of its work. Social work services are seen as working with GPs, and in the East we think of IV drug users going to Social Work and getting help there somehow." (Dr. Linda, Psychologist, Hospital Health)

The stance taken by Hospital Health managers, who maintained that their remit was exclusively orientated to the treatment of alcohol misuse, caused much consternation across the health and social work managerial communities'. The A&DD's discrimination between 'alcohol' and 'drug' addiction was viewed dismayingly by Community Health and Specialist Service managers, who argued that the A&DD's service *"should be for alcohol 'and' drugs, not just alcohol."*

As the East and North Glasgow populations suffered the highest rates of alcohol misuse in the city, many believed that *"the lines of demarcation"* which Hospital Health managers had drawn up were purely for the purpose of *"stemming the flow,"* and to limit the number of cases they would have to assess and treat.

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their perceptual state to be monitored in the event of severe withdrawal in the form of Delirium Tremens ('the DTs'). The treatment is carried out at the patients' home, or in specialist psychiatric units, depending on the severity of withdrawal and associated physical risks such as cardiac arrest and seizures.

Regardless of their unpopularity, Hospital Health managers declared that their service was *"clearly demarcated as a specialist medicine body,"* that addressed alcohol misuse only. To reinforce its policy, it decided that all alcohol referrals for the East and North were required to go through the A&DD's consultant psychiatrist's first. Referrals were only accepted by these psychiatrists from GPs or fellow medical colleagues, and not from anyone else.

In the eyes of Hospital Health managers, Social Work referrals held no credibility. SW managers were entirely dependent on GPs to access help. They had found that this often involved *"persuading"* GPs to refer their clients for alcohol detoxification treatments. GPs were bemused that social work and voluntary groups could not directly refer 'detox cases' to alcohol health services, and argued that *"it would make more sense if these agencies would just work together rather than getting us involved."*

"Ideally, we would like to refer clients directly to psychiatrists or psychologists at the hospital. But we have to tell them that they have to go to their GP first. That can be a nightmare. They walk in here all fired up and motivated to stop drinking, then we burst the bubble for them." (Pauline, Glasgow Council for Alcohol, Specialist Service)

"There is no opportunity to refer clients into NHS alcohol or mental health services. We have got a psychiatric hospital on our doorstep, but we can't access it or get anybody seen by a doctor there." (Joe, SW, Operations Manager, East CAT)

General dissatisfaction with *"the inconsistency of services,"* and the responsibility for alcohol-related cases falling heavily upon other services other than the A&DD, was commonly cited as to why a new approach to improving access to alcohol services ought to be adopted. By establishing CATs as the starting point for alcohol service users, top management anticipated that access issues would improve if there were no longer organizational boundaries and lines of demarcation. Hospital Health manager's expressed their **disapproval** of CATs being officially designated as the single point of entry for alcohol addiction support, as the A&DD would no longer be the first port of call for referrers.

SECOND-ORDER ANALYSIS

Time 1 narratives are now analyzed further to examine how Hospital Health manager's disapproval of Goal 3 was influenced by their legitimacy and commitment evaluations, and whether the relationship between these evaluations was reciprocal or non-reciprocal.

Example 13: Hospital Health managers

Hospital Health manager's conferred **low pragmatic legitimacy** upon Goal 3, in the variant forms of *influence* and *exchange* legitimacy. On an influence level, they were concerned that they would no longer be able to control the flow of alcohol referrals in and out of their service. They argued that a single point of access via CATs was not required, as the current system that they had put in place for alcohol patients was sufficient and working well. Their imminent loss of authority to decide if, when, or how alcohol patients should be treated, was the recurring theme throughout Time 1 interviews.

On an exchange level, clinicians would now be accessible to SW managers who could now directly refer their clients to the A&DD for psychiatric assessment or hospital admission. Worried Hospital Health managers forecast that they would become *"too accessible,"* and be *"overloaded"* as a consequence of opening up referral pathways to SW managers. They expected non-medical agencies to view them as "*some kind of emergency service,"* and anticipated that these agencies would *"start to medicalize problems"* in order to shift the responsibility of individual's care onto the A&DD.

"If we open up the doors to allow referrals to come directly to us from CAT social workers, well, I'm not quite sure how we would ever get through that potential number of referrals. Our waiting list would be so long that we wouldn't be able to provide a service to anyone. I'm not sure we could stretch that far. The demands on us will be huge because we will be a new resource to Social Work. We are already fearful about being overburdened. That is definitely a concern we have." (Dr. Linda, Psychologist, Hospital Health)

Hospital Health managers did not believe it was in their interests to support the new access system via CATs. By expressing such views, they merely confirmed the long-held suspicions of other partner agency managers that 'lines of demarcation' were set up as a control mechanism to *"stem the flow"* of new referrals.

"I'm not sure if there will be huge changes to the number of alcohol patients coming our way, but it might mean that IV drug users are referred to us due to their mental health difficulties. Whether we accept them or not, I'm not so sure. There are some prejudices about working with people with IV drug problems. Colleagues that I have spoken to, do seem to have a preference about working with one or the other patient groups."

(Dr. Linda, Psychologist, Hospital Health)

Hospital Health managers expressed **low attitudinal commitment** to moving towards a single point of entry. They were critical of top management's plans to change existing access arrangements, and very negative about the likelihood of success in doing so. Their pessimism about the future of alcohol services within an integrated structure was borne out of past experience. Over the past decade, Glasgow's alcohol services was *"the poor relation"* who *"played second fiddle"* to drug services for opiate misuse. Hospital Health managers pointed out that alcohol services had been under-resourced for many years, as "*alcohol misuse was lower on the agenda in Glasgow, because all addiction resources are channelled into Social Work for IV drug users."*

This trend was attributed to political and media campaigns that followed the publication of rising drug deaths, as well as public concerns about the impact of opiate addiction on child protection issues, criminality, and prostitution. It was *"the illegality of drugs making the front pages"* that reinforced these managers' view that *"drugs had the higher profile in Glasgow,"* whereas *"alcohol always loses out."* With the introduction of CATs, they had no reason to believe that alcohol services would suddenly be better resourced or represented within an integrated structure as a way of *"redressing the balance,"* or that alcohol service users were going to get *"a fair crack at the whip."*

Second-order analysis point

At Time 1, Hospital Health managers' evaluations suggested that the L-C relationship was reciprocal. For example:

(71: HH) Low pragmatic *(influence)* legitimacy coexisted with low attitudinal commitment

(72: HH) Low pragmatic *(exchange)* legitimacy coexisted with low attitudinal commitment

THIRD-ORDER ANALYSIS

The reasoning which underpinned Hospital Health manager's legitimacy and commitment evaluations of Goal 1 is now examined on a third-level of analysis. It explores how their evaluations were shaped by umbrella context factors. It explores how their evaluations were shaped by umbrella context factors i.e. clarity of direction, partial control, clarity of roles, ambiguity over boundaries, issues around autonomy and discretion, co-optation,

participation, and the extent that all of these factors had on developing the finer details of the strategy en route[49].

'How are we supposed to know where we are going?'

At Time 1, Hospital Health managers conferred **low cognitive legitimacy** upon Goal 3. They described not having enough detailed information to be able to comprehend how the single point of entry into CATs was supposed to work in practice.

"I haven't got the foggiest how the integration will make an impact because I don't think they have got the foggiest. They have now been in place for how many weeks? And to the best of my knowledge they don't even have a concept of how their referrals are coming to them. They haven't spoken to the GPs yet. Hello! I don't think they will know if it's working well or not, so how the dickens am I to know?" (Dr. Jack, Psychiatrist, Hospital Health)

'En route strategizing is 'strategizing on a whim''

The deliberately-emergent approach that was adopted by top management also helped explain why Hospital Health managers conferred **low moral legitimacy**, in its variant form of *procedural legitimacy*. Hospital Health managers repeatedly asked the question: "*Why is this all so chaotically organized?"* Both parent organizations had undertaken two lengthy consultation processes during the previous year, but those from the A&DD complained that the planned elements of the integrated strategy *"had not been thought through."* Like their Community Health colleagues, they questioned the robustness of the strategy-making process and complained that there was no performance framework from which to measure what CATs were achieving on a national or local level.

These managers were firmly 'pro-planning' in their notions of strategic management. Their firmly-held views on how strategic change *"should be done,"* strongly influenced their strategy legitimacy evaluations. En route strategizing activity was perceived as *"doing everything on a whim,"* without any detailed data gathering, formal analysis, or strategy workshops. They were highly resentful that top management had failed to develop the integrated strategy without co-opting them into any formal strategy planning process.

"I would have thought it would have been politically correct or appropriate for someone to have met me before all this. If I could meet the Operations Managers, it might help. They've

[49] Chapter 8 discusses and elaborates further upon how umbrella context factors appeared to influence strategists' practices en route.

been appointed for nearly two months now, and I have not had one telephone call from them. To me, that suggests the level of communication is pretty poor. No, it is appalling! I mean, that is almost unheard of if you were setting up any other service. Somebody, somewhere, would say 'oh, we can arrange to see you to get an idea as to what to provide?' I haven't had a call yet." (Dr. Jack, Psychiatrist, Hospital Health)

The strategy lacked *"the evidence"* that clinical governance standards had been *"taken seriously,"* or that enough consideration had been given to how Psychology Services should *"fit in."* Hospital Health managers stressed that *"some long and hard conversations"* about the single point of entry still required taking place.

"If they are clear about their remit, and clear about their referral routes in and out of these teams, and how they link with the hospitals and specialist services, then OK, fine. Clear demarcation as to who is doing what, which is dictated by confidence rather than by whim, is what is lacking. I don't see any clinical governance anywhere. They should be saying, 'if we are not going enough to do x, then we will confine ourselves to y'. I am not confident about the people working on this. I've not got any concept as to where they are coming from. I still haven't picked that up." (Dr. Jack, Psychiatrist, Hospital Health)

As no in-depth patient consultation had taken place as part of the planning process, Hospital Health managers claimed that their [alcohol] patient group would not look favourably upon having to visit GCC Social Work Services buildings, where East and NE CATs were located. They also predicted that a new access system, which included social workers, would compromise clinician's therapeutic relationship with patients as soon as they were aware that the A&DD was obliged to share patient information with CAT SW managers. They were keen to point out *"that at least their patients knew there were parameters of confidentiality in the NHS."*

"Confidentiality is obviously going to be an issue. I think our patients are frightened of going to Social Work and suddenly having their children taken away. Their preconceptions of Social Work will hinder them going to CATs. We are still looking at the CAT as a Social Work Department, no matter what publicity you do. There are all sorts of connotations of going to Social Work. Our patients don't want to set foot in it when it's medical help they want. And that is the word from the street." (Stephen, Nurse, Hospital Health)

Third-order analysis point

Hospital Health manager's third-order evaluations did not change the nature of the L-C relationship, as it remained reciprocal. For example:

(73: HH) Low cognitive *(comprehensibility)* legitimacy coexisted with low attitudinal commitment

(74: HH) Low moral *(procedural)* legitimacy coexisted with low attitudinal commitment.

TIME 2 (May.04)

FIRST ORDER ANALYSIS

'Alcohol services are no longer the poor relation'

By Time 2, accessing help for alcohol addiction via CATs had markedly improved. It had become easier for clients who were seeking alcohol detox treatment to receive help quicker than it had been previously prior to CATs being introduced. No longer were they waiting up to nine months to be assessed for suitability for an alcohol detox programme by the A&DD psychiatrists. Clients were now being referred straight into CATs, and it had become commonplace for them to be assessed by CAT nurses within one or two weeks, and then immediately commenced on treatment.

The 'postcode lottery' effect , that had for so long dictated how soon alcohol clients would be seen under the old system, was no longer a determining factor for those seeking help for alcohol addiction. Quick access was equally prevalent across both East and NE localities. Alcohol service users had finally got the *"fair crack at the whip"* that Hospital Health managers had long argued had been denied them.

The unofficial lines of demarcation, which had previously been enforced to 'stem the flow' of referrals to the A&DD, were no longer in operation. These had effectively become irrelevant and outdated since the implementation of Goal 3. Community Health, Specialist Service, and SW managers found that the A&DD still remained very much 'alcohol-orientated,' but structural changes to the service meant this was no longer a major issue for them. Each of these managerial groups publicly recognized the home detox programme as an early success of the CAT strategy.

Hospital Health managers now **approved** of Goal 3, and boasted how the community alcohol service was *"the bright light"* of the new addictions strategy.

"There is a vast improvement in terms of access if you have lived in an area where a home detox wasn't available. It has made a big difference. The GPs are happy and the patients are happy. You can now get a nurse to go to your door to address your issues, compared to having to go a waiting list to be assessed, then another waiting list to be treated."

(Stephen, Nurse, Hospital Health)

SECOND-ORDER ANALYSIS

Example 14: Hospital Health managers

At Time 2, Hospital Health manager's conferred **high pragmatic legitimacy**, in its variant form of *exchange legitimacy*. Their initial fears, that there would be a wave of referrals from SW managers to assess and treat those with IV drug misuse coexisting mental health problems, didn't materialize. They found that their workload levels had not risen dramatically as they had anticipated, and that the diversion of referrals away from the A&DD meant that their clinicians were now able to focus more heavily on their acutely unwell hospital inpatients, as opposed to spending time on outpatient assessment requests from GPs.

Hospital Health managers revelled in the fact that alcohol services had been unaffected by the GP contract issue in the way it had limited the development of the methadone programme. They also claimed the success of the integrated alcohol service as their own, because they had previously promoted the importance of alcohol home detox as part of their own strategic plan for the East and North of the city. They saw its success as portraying the A&DD in favourable light.

"The alcohol side of things is working really well, whereas the drug side of things now have their own problems to contend with. The alcohol part is the one area that is well and truly shining through. But a lot of what has happened with the CATs was really the good parts of the Directorate's Alcohol Strategy which we had already thought about two years ago. Everyone knows we have been talking about improving access to community detox even before the CATs came along." (Stephen, Nurse, Hospital Health)

Hospital Health managers engaged in a level of co-operation with CATs that their Time 1 narratives suggested was highly unlikely. Their actions now signalled **high behavioural commitment** towards Goal 3. For example, the A&DD's psychologist visited East CAT to explain her role to SW managers, and began a dialogue around how the CATs and Psychology Services might be able to work together more formally.

Despite their initial objections about the location of CATs, Hospital Health managers became more relaxed about advising their patients to go to GCC's Social Work Services buildings should they require contacting their local CAT. These managers were now *"comfortable with the concept of CATs."*

Second-order analysis point

At Time 2, Hospital Health managers' evaluations suggested that the L-C relationship was reciprocal. For example:

(75: HH) High pragmatic *(exchange)* legitimacy coexisted with high behavioural commitment.

THIRD-ORDER ANALYSIS

'Bringing middle managers into the strategic conversation'

Hospital Health managers conferred **high moral legitimacy** upon Goal 3, in its variant form of *procedural legitimacy*. This followed a series of meetings with top management and East and NE CATs' Operations Managers. The outcome of these meetings was very successful.

"We started to have monthly meetings with the top guns and the Operations Managers, which have at least created a dialogue about what the problems are. So that has helped. I can access the Operations Manager's straight off now, no problem. The lines of communication are now established." (Dr. Jack, Psychiatrist, Hospital Health)

Hospital Health managers subsequently conferred **high pragmatic legitimacy** in its variant form of *influence legitimacy*. This followed sending several letters to top management throughout Dec.03 – Jan.04 expressing their concerns about Goal 3. The newly appointed Joint General Manager responded by suggesting they set up face-to-face meetings from Feb.04 onwards to address the A&DD's concerns.

At the first meeting, Dr. Jack agreed to write to all local GPs requesting that any future alcohol referrals that required less specialist or intensive [hospital] input be redirected to the East and NE CATs.

"I sent a general letter out saying, 'please now refer your patients to CATs'. We are still getting some referrals from them, but when we do, we write back to each GP and say, 'in future, refer your patients to CATs'. What we are also saying is that if they feel that the patient has more complex needs, then they should refer to us at the hospital. But for normal alcohol addiction problems, it would be more sensible to refer to CATs'."

(Dr. Jack, Psychiatrist, Hospital Health)

It was also agreed that a 'link nurse' from each CAT would attend the A&DD's weekly department meetings to review those referrals which had been sent to the hospitals in the East and NE areas. In practice, Hospital Health managers found this process to be generally straightforward. They negotiated with the link nurses which referrals the East and NE CATs would take, and which ones would be retained by the A&DD. It allowed Hospital Health managers to retain some, albeit less, authority to decide which patients they would accept into the A&DD's services. They felt that they had regained some control over the flow of alcohol referrals in and out of the A&DD.

Hospital Health managers discovered that this arrangement worked in their favour, as many of the referrals which CATs were to assess patient's suitability for an alcohol home detox. The A&DD's clinicians would no longer require placing these types of referrals on their waiting list for assessment as they had previously done. Prior to Time 2, their waiting list time had decreased from nine months to four weeks. Their long-standing reputation as a poor service with an *"astronomical"* waiting list seemed no longer justified, and they now claimed to be a *"perfectly efficient service."*

'Top management intervention produces a positive response'

Following top managements engagement with the A&DD, Hospital Health manager's subsequently expressed **high attitudinal commitment** towards Goal 3. Although deeply critical at Time 1 about the general approach towards creating improved and equitable access for alcohol service users, Hospital Health managers now believed that top management were making a concerted effort to help develop Goal 3 en route, and that their intervention had helped resolve a number of problems which had not been addressed earlier within the CAT strategy document.

Third-order analysis point

Hospital Health manager's third-order evaluations did not change the nature of the L-C relationship, as it remained reciprocal. For example:

(76: HH) High moral *(procedural)* legitimacy coexisted with high attitudinal commitment

(77: HH) High pragmatic *(exchange)* legitimacy coexisted with high attitudinal commitment

(78: HH) High moral *(procedural)* legitimacy coexisted with high behavioural commitment

(79: HH) High pragmatic *(influence)* legitimacy coexisted with high attitudinal commitment

(80: HH) High pragmatic *(influence)* legitimacy coexisted with high behavioural commitment

TIME 3 (December.04)

FIRST ORDER ANALYIS

'Access is open to some, but not to all'

During the first year of the integrated strategy, the single point of entry overwhelmingly benefited those seeking help with their alcohol addiction. However, CAT Health managers had gradually begun demarcating the role of their teams in relation to patients with alcohol problems that coexisted with mental health problems i.e. 'co-morbid' patients, who suffered from depression, anxiety, psychosis, or self-harm as well as alcoholism.

It was unclear to Hospital Health managers how these patients would be supported in the community setting if CAT managers were refusing to accept them once they were ready to be discharged from hospital, or where additional community support was supposed to be available for those patients who received psychological therapy at the hospital's outpatient departments. The position of Hospital Health managers was no longer one of approval, but one of **ambivalence**.

SECOND-ORDER ANALYSIS

Example 15: Hospital Health managers

At Time 3, Hospital Health managers conferred **low moral legitimacy** upon Goal 3, in its variant form of *consequential legitimacy*. The main issue of concern for Hospital Health manager's was no longer 'how' CATs could be accessible via a single point of entry, but to 'whom' they were accessible to. From the single point of entry being unworkable and unnecessary to them at Time 1, to working well at Time 2, it was now seen as inadequate for those with more complex problems. The aim of equitable access had not been accomplished as the co-morbid patient group were seen to be *"losing out."*

"Co morbid patients are a highly prevalent group when it comes to addiction, but we have not addressed how we manage them within an integrated system. The ones who won't attend hospital outpatient appointments are slipping through the net, because we have no one who does the 'home visit' part of our work anymore." (Dr. Linda, Psychologist, Hospital Health)

There was no longer community psychiatric nurse support available to the A&DD because those nurses who previously carried out this role within the Directorate had all joined the East and NE CATs. Although CAT nurses attended weekly meetings with Hospital Health

managers, they had began *"bouncing back"* or 'buffering' these types of referrals on the grounds that they did not have the nursing resources to cope with them.

"If I have got somebody who is depressed and has a drink problem, what the CAT nurses say to me is 'our bosses tell us that we only look after simple addiction problems'. So we don't seem to have any service that look after those people in the community who have these kinds of complex problems" (Dr. Jack, Psychiatrist, Hospital Health)

Community Mental Health Teams ('CMHTs') simply refused to accept referrals for this group of patients on the grounds that *"they were not specialized enough to deal with them."* They had started to advise GPs to direct their co-morbid referrals into CATs by routinely citing national guidelines which stated that if the patient's primary problems were alcohol-related, then CMHTs were not the most appropriate service to refer to. The *"pillar-to-post effect,"* which Goal 3 had been designed to eradicate, was still in operation for the co-morbid group.

In spite of their concerns about access to CATs for co morbid patients, Hospital Health managers expressed **high attitudinal commitment** towards delivering Goal 3. They believed that the imbalance between services for those with alcohol and drug problems was seen to have been redressed for the most part. They anticipated that their successful operational relationships with CAT 'link nurses' would continue to work well for the wider [non-complex] alcohol population. They were also hopeful that the introduction of the 'Psychology-CAT Interface,' which allowed referrals to come through CATs and onwards to Psychology, would produce positive results and reduce waiting times.

<u>Second-order analysis point</u>

At Time 3, Hospital Health managers' evaluations suggested that the L-C relationship was non-reciprocal. For example:

(81: HH) Low moral *(consequential)* legitimacy coexisted with high attitudinal commitment.

THIRD-ORDER ANALYSIS

'Middle managers reframe their notions of success en route'

Hospital Health manager's conferred **low cognitive legitimacy** upon Goal 3. Although the single point of entry via CATs had significantly improved access to treatment for the wider

alcohol population, these managers appeared to reframe their initial concerns about Goal 3 by turning their attention to the lack of planning and detail provided in the strategy document to address access into CATs for *"those at the more severe end of the spectrum"* i.e. co-morbid patients.

In reframing their objections to Goal 3, they downplayed the success of improved access to alcohol home detox. They were no longer prone to hailing the success of better access to treatment in the same way as Community Health, Specialist Service, and CAT managers continued to do. The alcohol service was now viewed by Hospital Health managers as *"only improved in patches."* They began to instead emphasize the lack of clarity around other aspects of the integrated strategy.

There had been no plausible guidance from the strategy document, or from conversations from top management, as to how the co-morbid issue might be addressed. Hospital Health manager's believed that there *"needed to be more direction as to where they were going"* as the routes in and out of CATs for these types of patients *"had not been crystallized."* This group of managers *"had expected some sort of seamless path"* to have been developed during the first year of CATs, but this had failed to materialize. Top management therefore *"needed to be very clear on what they wanted clinicians to do,"* because *"things were still very murky,"* and *"difficult to understand"* with regards to who was ultimately responsible for the management of the co-morbid group at different stages of their care.

'The mismanagement of umbrella strategizing'

In response to Hospital Health managers' concerns about co morbid patients, top management decided to embark on a new [third] consultation exercise about how best to manage these types of patients. A consultation document which offered a number of proposals was drawn up, but it failed to gain approval from NHSGG's executives. This resulted in the top manager responsible for drafting these proposals handing in her resignation, only to be later persuaded to remain involved in the strategy process.

This incident contributed to Hospital Health manager's conferring **low moral legitimacy**, in its variant form of *procedural legitimacy*. It was another indication to them that the emergent process was being *"poorly managed,"* and was *"ill-thought out."* They did not believe that top management had considered in enough detail the problems of dealing with the co-morbid group. This was despite repeated requests by the A&DD for top management to do so since CATs were introduced one year earlier.

The recommendations that Hospital Health managers planned to submit as part of the [third] consultation exercise were no different to those that they had submitted two years previous. They questioned why they were required to repeatedly state what required to be done to develop services for the co-morbid group, and why top management required to be told on three consecutive occasions what ideas, that they as middle managers, had to offer. Top management were accused of not prioritizing the needs of those with complex problems, but of instead being preoccupied by the recruitment and selection process of new members to the joint management structure.

"I honestly think that the whole process has been mismanaged. Conceptually, this is all a great idea. I think it could work, but there has been such poor communication with us, and they are always playing catch up. It has been a shambles because they have been so busy getting the management structures put in place that they have not had time to push through other important developments. Too many of them have been focusing their energy on getting the top jobs in the new structure." (Dr. Jack, Psychiatrist, Hospital Health)

Hospital Health managers also argued that top management should have foresaw the issue of where co morbid patients should be best managed. They argued that this particular issue had already been highlighted by A&DD clinicians on many occasions as part of the two major consultation exercises that preceded the introduction of CATs. Not only had top management initially undertaken a low level of analysis of the problems associated with alcohol misuse, but that their deliberate-planned decision to focus so heavily on those requiring home alcohol detox treatment was to the detriment of those patients with more complex needs. Therefore, earlier strategic decisions which top management had planned and agreed upon were now seen as flawed, with little attention paid to the CAT's capabilities to support co morbid patients.

"If these people are moved into the CATs, their care will be compromised because there is not enough experienced staff there to cope with them. One of the things that they have not concentrated on is whether they have the knowledge and skills base to deliver a service for those with complex needs." (Stephen, Nurse, Hospital Health)

"The CATs development was haphazard. They had the money to spend on the CATs, but they didn't plan it. What they haven't got right is that they have invested a lot of money for the wider alcohol population at the expense of the people at the severe end of the spectrum. They

then tapped into the money for hospital services to prop up CATs, which meant that our services are more depleted. It's all upside down." (Dr. Jack, Psychiatrist, Hospital Health)

Hospital Health manager's conferred **low pragmatic legitimacy**, in its variant form of *influence legitimacy*, as they no longer felt that they were being well-represented at top management level. NHSGG members of the interim top management team had failed to inspire any confidence in Hospital Health managers, because they *"lacked the enthusiasm"* or showed any leadership during the strategy process. Concerns were raised about their competency to manage such a major strategic initiative across organizational boundaries.

The unexpected movement of two key top health strategists during the strategy process caused *"major instability."* Although designated as the most senior top-level representatives of Hospital Health managers, they were described as *"disorganized,"* and their strategic leadership viewed as *"shambolic."*

"The top Health guys were saying to us, 'this is never going to happen'. So we were getting fed misinformation. The integration then goes ahead and it happens, and it made us all look foolish as there was no clear consensus on what we should do. We were left absolutely blind. We had no real information on what was going on, that was the biggest issue"

(Stephen, Nurse, Hospital Health)

Hospital Health managers believed that *"Health had become a bit of a laughing stock when it came to managing change."* They argued that those top managers who *"shot the craw"* should not be allowed to escape criticism for their actions, which would have been regarded as unacceptable within any other health service environment. The departure of these key individuals at different stages of the development and implementation process led to feelings of anger, resentment, and abandonment among Hospital Health managers. Gradually, they had found themselves in a position with little influence on the en route strategy decision-making process.

"It has been an absolute guddle in the last twelve months, from the CEO being very much involved in things, and then suddenly being the invisible man. Then our line manager at the top buggering off was the worst thing that happened to us. He was in denial about the new Joint General Manager coming from Social Work, so he upped and left. It was a disgrace. The man should never have been allowed to leave. It put us back six months. If you did this in a clinical role, you would have been slated. If you had a caseload of patients and just said 'I

can't be bothered carrying on here,' you would get strung up. But in management terms, that seemed ok." (Stephen, Nurse, Hospital Health)

To compound matters for them, Hospital Health managers were unhappy that the meetings they had been holding with top management and both Operations Managers, had suddenly stopped over the last six months. The lines of formal communication that had been established several months back had now faded. They had received no explanation for this, but felt that it was not they who were responsible for maintaining these en route development meetings with top management.

"One minute you're in, and the next minute you're out. They don't seem get it that you must continue to communicate with others. It all seems a bit random when they want to talk to us." (Stephen, Nurse, Hospital Health)

'Active strategists decide to take up a passive role on the periphery'

The *"lack of consistency"* in top managements approach to the ongoing development of Goal 3 induced a negative response from Hospital Health managers. They became reluctant to remain engaged in the en route emergent process. Despite the need to develop the finer detail around addressing access issues for the co morbid group, Dr. Jack the psychiatrist, and Stephen the nurse[50], decided that they would retreat and withdraw from the process. Dr. Linda the psychologist soon left the A&DD altogether. All of their actions signalled **low behavioural commitment** towards retaining a role as influential strategists.

"I have to say, I am trying to be peripheral to it all now. Just do my clinical work and get on with it." (Dr. Jack, Psychiatrist, Hospital Health)

"Och, I'm more inclined to stand back from things now and let others get on with it. I've put a lot into this whole process for the alcohol side of things and at the end of the day, sometimes those up above listen and sometimes they don't."

(Stephen, Nurse, Hospital Health)

<u>Third-order analysis point</u>

Hospital Health manager's third-order evaluations affected the L-C relationship in two ways.

[50] Stephen was expected to be appointed as Lead Nurse within the new joint management structure. However, to many CAT and partner agency managers' surprise, it was awarded to Margaret, the former Operations Manager for NE CAT.

On one level, it remained non-reciprocal. For example:

(82: HH) Low cognitive *(comprehensibility)* legitimacy coexisted with high attitudinal commitment

(83: HH) Low moral *(procedural)* legitimacy coexisted with high attitudinal commitment

(84: HH) Low pragmatic *(influence)* legitimacy coexisted with high attitudinal commitment

On another level, the L-C relationship changed to reciprocal. For example:

(85: HH) Low cognitive *(comprehensibility)* legitimacy coexisted with low behavioural commitment

(86: HH) Low moral *(procedural)* legitimacy coexisted with low behavioural commitment

(87: HH) Low pragmatic *(influence)* coexisted with low behavioural commitment

(88: HH) Low moral *(consequential)* legitimacy coexisted with low behavioural commitment

Table 7 Summary data analysis

Goal 3: To provide equitable and improved access to alcohol services

Time	Sub-group	1st order	2nd order	L-C relationship	3rd order	L-C relationship
1	**Hospital Health managers**	Disapproval	Low pragmatic (*influence* and *exchange*) legitimacy Low attitudinal commitment	Reciprocal	Low cognitive *(comprehensibility)* legitimacy Low moral (*procedural*) legitimacy	Reciprocal
2		Approval	High pragmatic (*exchange*) legitimacy High behavioural commitment	Reciprocal	High moral (*procedural*) legitimacy High pragmatic (*influence*) legitimacy High attitudinal commitment	Reciprocal
3		Ambivalence	Low moral *(consequential)* legitimacy High attitudinal commitment	Non-reciprocal	Low cognitive *(comprehensibility)* legitimacy Low moral *(procedural)* legitimacy Low pragmatic *(influence)* legitimacy Low behavioural commitment	Reciprocal & Non-reciprocal

CHAPTER 8

DISCUSSION & ANALYSIS

The purpose of this thesis was three-fold. First, to examine the relationship between strategy legitimacy and strategy commitment from a strategy-as-practice perspective, and to question the normative view within the wider strategy and management literature that suggests there is a reciprocal relationship between gaining legitimacy and attaining actor's commitment which, in turn, supports successful strategic change. Second, to examine whether umbrella strategy conditions (Mintzberg & Waters, 1985) play a role in shaping middle managers' strategy legitimacy and commitment evaluations, and to what extent these conditions influence their strategic reasoning, practices, and strategizing activities (Johnson et al, 2007). Third, to examine how middle manager practices, which emerge during umbrella strategies, are consequential for change outcomes (Jarzabkowski et al, 2007). The data reveals a number of important findings in relation to these three central research questions.

8.1 The strategy-legitimacy commitment relationship

Q1. What is the nature of the relationship between strategy legitimacy and strategy commitment as change unfolds?

First, the data findings show that, during strategic change, the relationship between strategy legitimacy and strategy commitment is more complex than the normative view suggests.

When legitimacy and commitment are analyzed as multi-variant constructs, they produce multiple types of legitimacy-commitment ('L-C') relationships. Some of these are reciprocal, and others non-reciprocal. By examining the narratives of five separate middle manager groups over three time periods, a total of 88 L-C relationship examples emerged. From these examples, 38 different L-C relationship-types were identified. 22 of these relationship-types were reciprocal (see Table 8.1)[51], however, 16 were non-reciprocal (see Table 8.2).

[51] As previously footnoted on p154, each analysis point was coded for reference purposes in terms of whether relationships were interpreted as reciprocal or non-reciprocal, and *when* they occurred. All 38 relationship-types are collectively illustrated in Tables 8.1 and 8.2. The asterisks (*) represent *the incidence* of each type of relationship over the three data collection periods (over T1, T2, T3) and highlights whether a particular type of relationship was found during second-order analysis or third order analysis, or both. Therefore, relationship-type No.1 (High pragmatic exchange relationship coexisting with high behavioural commitment occurred twice at T1, once at T2 etc.) The right-hand column titled 'Coded analysis points' simply outlines the number given to each chronological example within the data chapters e.g. '3 SS' incidates that this is example number 3, and relates to Specialist Service managers; '36 HCO' indicates that this is example number 36 and relates to Horizontially Co-opted managers, and so forth).

These findings show that, during the ongoing development and implementation of strategy goals, the strategy L-C relationship is not exclusively reciprocal. The relationship can also be non-reciprocal, as some forms of strategy legitimacy can develop despite strategy commitment not transpiring as intended (and vice versa). In some cases, middle manager's L-C evaluations simultaneously produced 'dual' relationships that are both reciprocal *and* non-reciprocal (see Tables 5.1, 5.2, 6.1, 6.2, and 7)

Table 8.1 Summary of reciprocal legitimacy-commitment relationship types

No.	L-C relationship type	2nd order T1	2nd T2	2nd T3	3rd order T1	3rd T2	3rd T3	Coded analysis points
1	High pragmatic *(exchange)* legitimacy High behavioural commitment	**	*					3 SS; 36 HCO; 75 HH
2	High pragmatic *(exchange)* legitimacy High attitudinal commitment					**		44 VCO; 77 HH
3	High pragmatic *(influence)* legitimacy High behavioural commitment					*		80 HH
4	High pragmatic *(influence)* legitimacy High attitudinal commitment					*		79 HH
5	Low pragmatic *(exchange)* legitimacy Low behavioural commitment			*			**	24 CH; 61 VCO; 68 HCO
6	Low pragmatic (*exchange*) legitimacy Low attitudinal commitment	**	*				***	1 CH; 27 CH; 34 SS; 42 HCO; 55 HCO; 72 HH
7	Low pragmatic *(influence)* legitimacy Low behavioural commitment						**	60 VCO; 87 HH
8	Low pragmatic *(influence)* legitimacy Low attitudinal commitment						**	50 VCO; 71 HH;
9	High moral *(consequential)* legitimacy High behavioural commitment	*						35 VCO
10	High moral *(consequential)* legitimacy High attitudinal commitment						*	64 VCO
11	Low moral *(consequential)* legitimacy Low behavioural commitment		*				***	29 CH; 41 VCO; 63 VCO; 88 HH
12	Low moral *(consequential)* legitimacy Low attitudinal commitment			*			*	18 CH; 32 SS
13	High moral *(procedural)* legitimacy High behavioural commitment					*		78 HH
14	High moral (procedural) legitimacy High attitudinal commitment					*		76 HH
15	Low moral *(procedural)* legitimacy Low behavioural commitment					*	****	10CH; 22 CH; 62 VCO; 66 HCO; 79 HH; 86 HH;
16	Low moral *(procedural)* legitimacy Low attitudinal commitment				**	***	**	5 CH; 11 CH; 25 CH; 31 SS: 37 VCO; 49 VCO; 74 HH
17	Low moral *(structural)* legitimacy Low behavioural commitment					*	*	12 CH; 28 CH

18	Low moral *(structural)* legitimacy Low attitudinal commitment		*	*			*	7 CH: 17 CH; 33 SS
19	High cognitive *(comprehensibility)* legitimacy High behavioural commitment				*			6 SS
20	High cognitive *(comprehensibility)* legitimacy High attitudinal commitment					*		43 VCO
21	Low cognitive *(comprehensibility)* legitimacy Low behavioural commitment						***	23 CH; 65 HCO; 85 HH;
22	Low cognitive *(comprehensibility)* legitimacy Low attitudinal commitment				*	*	***	4 CH: 26 CH; 48 VCO; 67 HCO; 73 HH

Table 8.2 Summary of non-reciprocal legitimacy-commitment relationship types

No.	L-C relationship type	2nd order T1	2nd T2	2nd T3	3rd order T1	3rd T2	3rd T3	Coded analysis points
23	High pragmatic *(exchange)* legitimacy Low behavioural commitment					*		46 VCO
24	Low pragmatic *(exchange)* legitimacy High behavioural commitment						*	21 SS;
25	Low pragmatic *(exchange)* legitimacy High attitudinal commitment						*	57 VCO
26	Low pragmatic *(influence)* legitimacy High behavioural commitment					*		53 VCO
27	Low pragmatic *(influence)* legitimacy High attitudinal commitment						**	56 VCO; 84 HH
28	High moral *(consequential)* legitimacy Low behavioural commitment						**	59 VCO: 69 HCO
29	High moral *(consequential)* legitimacy Low attitudinal commitment	*			*		*	2 CH; 39 VCO; 70 HCO
30	Low moral *(consequential)* legitimacy High behavioural commitment		*	*				8 SS; 19 SS
31	Low moral *(consequential)* legitimacy High attitudinal commitment					**	**	13 SS; 47 VCO; 54 VCO; 81 HH
32	Low moral *(procedural)* legitimacy High behavioural commitment				**	**	*	15 SS; 30 SS; 38 VCO; 40 HCO; 52 VCO
33	Low moral *(procedural)* legitimacy High attitudinal commitment						**	58 VCO; 83 HH;
34	Low moral *(structural)* legitimacy High behavioural commitment		*	*				9 SS: 20 SS
35	Low moral *(structural)* legitimacy High attitudinal commitment					*		16 SS
36	High cognitive (comprehensibility) legitimacy Low behavioural commitment					*		45 VCO
37	Low cognitive (comprehensibility) legitimacy High attitudinal commitment						*	82 HH
38	Low cognitive (comprehensibility) legitimacy High behavioural commitment					**		14 SS; 51 VCO

Second, the data findings show that separate middle manager groups confer different forms of legitimacy, and commit to strategy goals in different ways, at different stages of the strategic change process.

For example, Community Health managers conferred low pragmatic (*exchange*) legitimacy upon Goal 1 at T1, while Specialist Service managers conferred high pragmatic (*exchange*) legitimacy upon Goal 1 at T1.Vertically co-opted CAT managers expressed high attitudinal commitment towards Goal 2 at T2, while horizontally co-opted CAT managers expressed low attitudinal commitment towards Goal 2 at T2. These conflicting dialogical accounts support the view that middle managers cannot be regarded as a homogenous group of actors who are situated in the middle of the organization and who interpret or support strategic change in the same way (Heracleous & Barrett, 2001; Thomas & Linstead, 2002).

This finding also resonates with Fedor et al's (2006) change commitment study which found that individual's willingness to support and work towards successful change was influenced by the favourableness (positive or negative) of the change for their own department members, the extent of the change in the department, and the impact of the change on the individual's job. The degree of emotional intensity for those closer to implementation (i.e. horizontally co-opted CAT managers) was stronger compared to those partner agency managers who were less so (i.e. Community Health and Hospital Health managers).

Fedor et al (2006) also suggested that when adaptation requirements are low, the change is embraced more so than when adaptation requirements are high, even when the change is generally favourable. This was certainly true in the case of Specialist Service managers versus the experiences of horizontally co-opted CAT managers. This also applies to differences in attitudinal commitment between vertically co-opted CAT managers (Joe and Margaret) who were less 'hands-on' in a day-to-day basis, compared to horizontally co-opted CAT managers who were more often found 'working at the coalface' and whose role adaptation requirements were higher. The increase in horizontally co-opted CAT manager's roles expectations eventually produced a negative emotional response, hence, their low behavioural and attitudinal commitment at T3.

Third, in most cases, increasingly more legitimacy and commitment variants could be identified from middle managers' narratives as change unfolded. Consequently, more L-C relationships emerged by T3 than were present at T1.

This suggests that middle managers' sensemaking becomes more complex as change unfolds, and that the basis of their L-C evaluations become increasingly multi-factorial over time. There are many more issues that they highlight in relation to strategy goals that they legitimize and delegitimize on different grounds, or commit and uncommit to, as time goes on.

Fourth, reciprocal strategy L-C relationships are more common during the early formative stages of the strategic change process than non-reciprocal relationships are.

To some extent, this finding supports the normative view within the strategy literature, which is based on non-longitudinal data, that legitimacy and commitment are reciprocal (Brown, 1998; Dess & Priem, 1995; Godard, 1999; Human & Provan, 2000; Lines, 2007; Novelli et al, 1995; Stone & Brush, 1996; Tyler & Blader, 2005). However, the data in this thesis also shows that as change unfolds over time, non-reciprocal and 'dual' relationships begin to emerge. By T2 and T3, these types of relationships became increasingly prevalent (see Table 8.2).

Claims of reciprocity in relation to strategy-making and planning processes are not disputed in this thesis (e.g. Eden & Ackermann, 1998; Kim & Mauborgne, 1992; Stone & Brush, 1996). Although what this data indicates is that the L-C relationship does not remain exclusively reciprocal in the context of umbrella strategies that involves more iterative and prolonged ongoing development and implementation activity. The strategy L-C relationship can become more complex as time goes on, and particularly so when umbrella approaches are adopted to manage strategic change.

Fifth, strategy L-C relationships are often temporal, particularly as strategic change progresses. Strategy legitimacy and commitment are both prone to fluctuation, and they rarely remain stable as actor's evaluations shift over time.

The data shows that the legitimacy of organizational 'claim(s)' (Kelman, 2001) i.e. espoused strategy goals, can be dynamic and fluid in the same way that an organizations' legitimacy (or legitimacy of the 'claimant') has been observed to be over periods of time (Brown, 2005; Deephouse & Carter, 2005; Elsbach, 1994; Scott et al, 2000; Suddaby & Greenwood, 2005; Zelditch, 2001; Zucker, 1987). There are clear shifts in actor's legitimacy evaluations at different stages of change with regards to the strategy's content and process. This mirrors Quinn's (1980) results that strategic consensus on strategy processes appeared "constantly in

flux" (p58). Perhaps this finding is not so surprising as legitimacy researchers have before pointed out that legitimacy assessments are prone to changing over time (Dacin, 1997; Ruef & Scott, 1998).

More importantly, the findings capture actor's level of commitment at different stages of change, which commitment researchers have highlighted change commitment studies has so far failed to do (Beck & Wilson, 2005; Fedor et al, 2006; Foote et al, 2005; Mowday, 1999). What actors commit to at one stage of the strategic change process does not necessarily mean that they will remain committed to the same goal at another stage. The level of middle manager's behavioural and attitudinal commitment can shift over time.

These findings contrast sharply with Neubart & Cady's (2001) study on program commitment. These researchers found that initial program commitment positively influenced commitment in the later stages of organizational initiatives. Neubert & Cady (2001) subsequently emphasized the importance of gaining commitment early in change initiatives, as initial program commitment is the strongest predictor of subsequent commitment. Their recommendation reflects the general view of the strategic change and HRM literatures about the need to create, develop, or win the commitment of actors at the beginning of change initiatives to ensure change efficacy (Balogun & Hope-Hailey, 2004; Barney, 1991; Guest, 1987; Huselid, 1995; Lee & Miller, 1999). Similarly, Ford et al (2003) found that individuals who were initially involved in the change effort were more likely to be committed to the strategy, and more likely to try out strategy-consistent behaviours on the job.

However, the findings of this study show that even if strategy commitment initially exists, it is not an antecedent to subsequent commitment. Early strategy commitment does not appear to influence actor's longer-term commitment towards change in the context of an umbrella strategy. Strategy commitment fluctuated, and was volatile and changeable. For example, Joe and Margaret, and several Community Health managers were closely involved in the formative stages of the CAT strategy, yet by T3, their behavioural commitment was low. Hospital Health managers twice offered their views via a formal consultation process about Goal 3, but at T1, they showed no sign of strategy-consistent behaviours. High behavioural commitment existed among horizontally co-opted CAT managers at T1, but this dissipated and later changed to low behavioural commitment by T3.

Sixth, a key characteristic of non-reciprocal and dual relationships was ambivalence (Piderit, 2000). The findings show that, quite often, middle managers neither approved nor

disapproved of individual strategy goals, but they were ambivalent about fully accepting the broad principles of each goal, or voiced concerns about the change process. Throughout the course of developing and implementing the strategy, change issues were not so black and white for middle managers. They were supportive, approving, and accepting of strategy goals on some fronts, but not on others.

Piderit (2000) has argued that employee responses to change can be multidimensional and ambivalent, and that their responses to a change initiative may be neither consistently negative nor consistently positive. One might have negative emotions but positive intentions towards the change. The identification of non-reciprocal L-C relationships adds support to Piderit's (2000) argument, as ambivalence was consistently characteristic of these types of relationships.

Middle manager ambivalence was discursively manifested by dialectic responses. Such responses shed light upon the legitimacy-commitment dilemma that middle managers face: 'is this the right thing to do?' and 'will I go along with it?' Dichotomous-like narratives conveyed how CAT middle managers were experiencing some degree of cognitive dissonance towards Goal 2 (Cooper, 2007; Festinger, 1957). Central to this internal conflict was the issue of whether the integrated approach was 'right for the clients' versus 'right for the managers'. Each of the five middle manager groups expressed such dissonance at different stages of change process, but especially at T3, as illustrated in the following abbreviated narratives in Table 8.3.

Table 8.3 Narrative examples of middle manager ambivalence

Group	Narrative
Community Health	*(T1) 'Indefinite substitute therapy is the wrong answer for everyone, but we have to hold fire at the moment as we are not too happy about what is being rumoured about our future involvement within the methadone programme'*
Specialist Services	*(T2) 'It's not right to separate patients from their GPs, but were are still prepared to transfer patients out of our services and into CATs'*
Vertically co-opted CAT	*(T3) 'Our cultural baggage hinders us but we shouldn't go back to the way things were before as this is undoubtedly the way to go'* *(T3) ''The political problems don't help us, but we need to prevent further tragedy'*
Horizontally co-opted CAT	*(T3) 'The fact that the nurses are in the same building has made some things easier for the clients. I just can't see how it could work for us if we don't have any guidance from top management'*

Hospital Health	*any guidance from top management'* *(T3) 'The notion of an exit strategy is right in principle, but we are not committed to the process top management have taken to achieve it.'* *(T3) 'The single point of entry is better for non-complex alcohol clients, but I don't want to be involved in the process any longer as top management have not gone about things in the right way for more complex clients'*

Non-reciprocal and dual relationships support arguments for researchers to revise traditional conceptualizations of resistance to change (Dent & Goldberg, 1999; Ezzamel et al, 2005; Piderit, 2000), particularly where issues of legitimacy and commitment are concerned. The complexity of these types of relationships suggests that the way in which actors evaluate legitimacy and commit to strategic change is not as dualistic or oppositional as the traditional views of early resistance researchers suggest (e.g. Coch & French, 1948; Lewin, 1947). These relationship-types show that theorizing resistance dualistically as 'compliance with' versus 'resistance to' oversimplifies middle managers' responses to change, and fails to appreciate the ambiguity and complexity surrounding resistance (George & Jones, 2001; Piderit, 2000).

Seventh, a second characteristic of non-reciprocal and dual relationships was when legitimacy variants and commitment-types conflicted and coexisted.

Middle managers frequently conferred more than one type of legitimacy upon strategy goals. These legitimacy variants sometimes conflicted with each other. When this occurred, it changed the nature of the L-C relationship from reciprocal to non-reciprocal. For example, second-order analysis shows that horizontally co-opted CAT managers conferred high pragmatic *(exchange)* legitimacy upon Goal 2 at T1, yet third-order analysis shows that they conferred low moral *(procedural)* legitimacy also. This changed the nature of the L-C relationship from reciprocal to non-reciprocal. Similarly, vertically co-opted CAT managers conferred low moral *(consequential)* legitimacy upon Goal 2 at T2, yet they conferred high cognitive *(comprehensibility)* legitimacy also. This also changed the L-C relationship from reciprocal to non-reciprocal.

This finding is important in relation to Suchman's (1995) point about the inter-relationships that legitimacy variants have to each other. It demonstrates that different forms of legitimacy can co-exist when evaluated by strategic actors during the process of change. This can subsequently affect the nature of the L-C relationship in terms of shifting it from reciprocal to non-reciprocal, as different forms, and levels, of legitimacy interact differently with behavioural and attitudinal elements of commitment.

It is also clear that strategy commitment variants can conflict and co-exist. For example, Specialist Service managers signalled their high behavioural commitment to Goal 1 at T3 by attempting to transfer their clients into CATs, but they expressed low attitudinal commitment as their earlier optimism around implementing the exit strategy had dissipated. Similarly, horizontally co-opted CAT managers expressed low attitudinal commitment towards the likely success of Goal 2 at T2, yet continued to show high behavioural commitment by continuing to carry out review and supervision sessions.

A consistent theme from horizontally co-opted CAT managers was that the integrated approach to creating an exit strategy might be 'right for the organization and the clients', but not necessarily 'right for managers'. At T3, these co-opted CAT managers acknowledged the benefits of nurses and social workers working together, but they also believed that the joint approach had diluted their sense of being 'professional carer's'.

Table 8.4 Narrative examples of middle manager ambivalence when legitimacy and commitment variants conflict and co-exist

Group	Narrative
Community Health	*(T1) 'It's the right way to go for the patients (high moral consequential legitimacy), but it's not great for us as GPs and what we are getting in return' (low pragmatic exchange legitimacy)*
Specialist Services	*(T3) 'We will still be trying to transfer our clients into CATs (high behavioural commitment), but we don't see how the exit strategy is going to work in practice' (low attitudinal commitment)*
Vertically co-opted CAT	*(T1) 'Middle managers' professional development is top of our agenda (high behavioural commitment), but we feel the horse has bolted the stable too soon before we have thought about what we are doing' (low attitudinal commitment)*
Horizontally co-opted CAT	*(T3)'There are clear proximity benefits to working in the same building in terms of clients having their needs addressed quicker (high moral consequential legitimacy), but this comes at an emotional cost to us' (low pragmatic exchange legitimacy)*
	(T3) 'There have been no positives for managers (low pragmatic exchange legitimacy), but there have been some positives for clients, which is what we are about and why we are here (high moral consequential legitimacy)'
Hospital Health	*(T3) 'We are still hopeful things will continue to improve for non-complex alcohol cases (high attitudinal commitment), but we are going to withdraw from the process (low behavioural commitment)'*

On a legitimacy level, there were few pragmatic benefits in exchange for attempting to support the new CAT clinic model, and the professional outcomes for these managers were

poor. Yet, they still maintained that the moral consequential benefits of the integrated approach were critical to clients' longer-term societal welfare and to provide them with a pathway towards full rehabilitation (Suchman, 1995).

On a commitment level, the data suggests that middle managers had internalized the concept of the exit strategy as a means of moving clients towards full rehabilitation (Kelman, 1958). Middle managers all supported clients' rights and entitlement to a better quality of care beyond being tied to methadone therapy. In this sense, their values were congruent with Scottish government policy, and top management's moral rationale for moving people on. However, they did not identify, or comply, with the steps that were required to be taken in order to implement the exit strategy as these were seen to compromise their own caring professional identities' i.e. *"I can't heal people anymore"*, *"we are supposed to be caring professionals"* etc.

Such legitimacy and commitment conflicts reflect those themes found in the identity literature (Ashforth & Mael, 1998; Dutton et al, 1994; Ezzamel et al, 2005). CAT managers appeared to be defending their identities by failing to behaviourally commit to the exit strategy on the grounds that it threatened their self-concepts (Dirks et al, 1996; Knights, 2002). It is clear from their narratives, that these middle managers were concerned about the way that the new CAT clinic model challenged their professional identities, and that they found difficulty in adapting to working practices that threatened their 'healing' and 'caring' self-concepts (O'Doherty & Wilmott, 2001; Woodman & Dewett, 2004).

8.2 The influence of umbrella conditions in shaping middle manager practices

Q2a. Do umbrella strategy conditions influence the conferring of strategy legitimacy and attainment of strategy commitment?

A strategy-as-practice concern which this thesis set out to address is the role and practices of individuals and groups of actors outside of top management teams (Balogun et al, 2007), as well as the context in which they strategize (Whittington, 2006).

The findings show that umbrella strategy conditions play a significant role in middle managers' legitimacy evaluations of, and their commitment to, strategic change. Third-order analysis of strategy goals across three distinct time periods provides extensive accounts of how issues relating to clarity of direction, ambiguity, control, autonomy, discretion, co-

option, participation and involvement, all influence how middle managers legitimize and commit to strategic change.

Strategic context factors would appear to help explain middle manager's strategic reasoning and what they *do* in practice when developing the finer details of an umbrella strategy en route (Johnson et al, 2007; Whittington, 2006).

Q2b. If so, how do umbrella conditions, and legitimacy-commitment issues, subsequently shape middle managers' practices?

A wide range of thinking, discursive, and behavioural practices can be identified from the data, with each relating to umbrella strategy conditions. These practices were coded and categorised under three umbrella strategy headings (i) clarity of direction using broad principles; (ii) control, discretion, and autonomy; and (iii) co-optation, participation, and involvement.

There are a variety of thinking, discursive, and behavioural practices that middle managers deploy when legitimizing and committing to strategic change under umbrella conditions. Some of these different types of practices can be intertwined, combine, and overlap around the same umbrella condition. Although not all middle manager groups exhibited every practice that is listed and identified through second and third-order analysis, some practices were more evident in certain middle managers groups than in others.

8.2.1 Clarity of direction using 'broad principles'

(TP1[52]): *'Seeking more specificity over generality'*

At T1, Community Health managers' narratives focused on their concerns about the clarity of direction that top management had provided on developing an exit strategy for methadone service users. An umbrella factor which shaped their thinking practices in relation to the 'broad principle' of Goal 1 was that there was a disproportionate emphasis on emergent strategizing, and doing things 'along the way' or 'en route', than there was on the few details which had been formally planned at the outset.

They conferred low moral (*procedural*) legitimacy upon Goal 1 as it appeared to them that the details around its implementation *"had not been thought through."* This, they argued, prevented them from being able to fully understand the wider implications of Goal 1 and

[52] Thinking practice ('TP')

what it actually entailed. They subsequently struggled to make sense of how the exit strategy ought to be developed and implemented. Their emergent sensemaking was characterized by speculation and conjecture, and the view that they were *"leaping into the unknown."*

Similarly, low moral (*procedural*) legitimacy evaluations about Goal 3 were shared by Hospital Health managers who offered the same line of reasoning about why it was difficult to establish what top management were expecting of them as strategists. Other than top management's intentions to reduce organizational boundaries and to establish a single point of entry for alcohol services, there was no detail beyond how this should happen.

Quinn's (1980) study of logical incrementalism, which was based on the opinions of top-level executives, showed how the "generality" of broad goals helped promote cohesion by ignoring detailed differences, and instead placed emphasis on widely-held common values relating to individual goals (p72). However, such notions of cohesion are far removed from how some middle managers interpreted the effects of generality in this case study. Too much generality, and too little specificity, had an adverse impact on the level of moral *(procedural)* legitimacy conferred upon Goal 1. In the context of this particularly umbrella strategy, many middle managers were less accepting of such ambiguity than Quinn's executives were. What played a role in their sensemaking was the need for more specificity and less generality in the umbrella strategy's' content and process.

Balogun (2006) points out that a managerial assumption of the planning school is that carefully-developed plans will deliver the expected results, and that the solution to unanticipated outcomes from this school is more and better planning (p31). While Vila & Canales (2008) have argued that strategic management discourse needs to place less emphasis on 'fixed plans' in order to build managerial commitment to strategy goals (p14). Yet, without 'enough' planning, middle managers appear less likely to legitimize the umbrella process. In many ways, the narratives of middle managers at T3 in this case study appeared to support the planning school view.

However, it may be that striking "the critical balance" (Quinn, 1980: p191) is perhaps more relevant to better umbrella strategizing than simply more planning. Some firms may need more specificity than generality in their deliberate strategic plans, yet the right balance can be difficult to gauge and finding it is arguably very subjective (Quinn, 1980; Mintzberg et al, 2009). Some middle managers appear comfortable working with fewer constraints while

others prefer top management to be more accessible and interventionist to sketch in their en route activity for them.

What this finding suggests is that where goals are deliberately planned and directly communicated to middle managers during the early stages of the strategy process, then what is perceived as 'enough' detailed specifics for top management is often at odds with what is 'enough' in the hearts and minds of middle managers. Indeed, by T3, many middle managers looked back and cited the broad principles of all three goals that were espoused, but that these had not received enough, or perhaps any, planning and development prior to implementation.

The findings also suggests that when two or more organizations together adopt an umbrella strategy, then perhaps more time spent on planning is necessary instead of allowing detailed aspects of the strategy to be developed on an emergent basis. Cross-organizational or boundary issues would appear to require more clarification for middle managers than when strategizing within their own single parent organization (Balogun et al, 2005; Huxham & Vangen, 2005).

(TP2): *'Ongoing attempts at making distinctions between what is considered as deliberate and what is considered as emergent'*

By T3, middle manager strategists failed to understand what the strategic priorities of top management were over the past year, or for the coming six months. These managers conferred low cognitive legitimacy at the beginning of the umbrella process because they struggled to make clear the distinctions between what was considered by top management to be deliberate and what was anticipated to be emergent. Despite the communication exercises, and the dissemination of the CAT strategy document to all middle managers, many could not easily distinguish between planned and emergent activity.

There appear to be some limitations to how the deliberate-planned elements of an umbrella strategy are conveyed to middle managers at the outset via the use of communication exercises. This data supports Vila & Canales (2008) view that "merely communicating strategy has serious limitations in aligning people with expected behaviour" (p4). The effects of earlier communication exercises upon GPs by T2, and Specialist Service managers by T3, weaned considerably to the extent that these managers had become increasingly confused and cynical about top management's efforts (Poole, 1989). Making the distinction between what

was planned and what was emergent as the strategy developed en route and things changed had become blurred and ambiguous.

What is clear is that the broad principles and central tenets of an umbrella strategy do require to be embellished with more explicit details prior to public pronouncements about what the organization aims to achieve. Where the "artful craft" (Quinn, 1980: p50) of managing this type of strategy process is not a top managerial competence, and the deliberate-emergent balance is not clear from the beginning, 'too little *or* partial planning' can be unhelpful to the extent that the strategy is perceived by middle managers (and external stakeholders) to be more akin to an emergent strategy than one which is deliberately-emergent (Mintzberg, 2007).

Perhaps an information-sharing or educational type of approach, that involves providing accessible background detail to middle managers about what factors guide and shape the basis of the strategies' content, requires to be balanced with highlighting which aspects of the strategy offer scope for development, adjustment, and modification, and which aspects do not. Namely, what aspects are guided by regulative institutional pressures and are set in stone and 'non-negotiable', and which aspects allow local experimentation and innovation. This may help middle managers resolve the ambiguities, confusion, and frustrations they experience when making sense of strategic goals en route or perhaps of the umbrella process itself.

(TP3): *'Discrepancy awareness increases when espoused intentions / the 'rules of the game' / strategy content or process have been altered en route'*

Middle managers' sensemaking in this case study show similar characteristics to those found in other studies regarding their information-seeking and cognitive processes (Balogun, 2003; Dutton et al, 1983; Gioia & Chittipeddi, 1991; Thomas et al, 1993). However, under umbrella strategy conditions, the focus of middle managers' attention specifically turned towards how the 'rules of the game' altered en route in relation to specific strategy goals. Discrepancy awareness was activated when top management changed what was initially offered as a 'deliberate' approach to instead adopting new, seemingly conflicting, and alternative approaches towards a strategy goal en route.

For example, there was a palpable sense of surprise, shock, and anger at top managements' decision to suddenly abolish the GDPS by T2, as this service was initially regarded as pivotal

to the success of the exit strategy. The priority was perceived to have shifted towards the financial issues relating to the GP contract as opposed to greater efforts towards developing and implementing Goal 1. This en route decision created low cognitive legitimacy among different groups of strategists.

By T2 and T3, middle managers were subsequently found to be asking more questions about the strategy content and process (Gioia et al, 1994) than they had done at T1. They began to notice to that what was initially proposed by top management was neither materializing nor consistent with what was initially espoused (Poole, 1989). This was reflected in them voicing stronger concerns about the strategy as it proceeded. Therefore, middle manager strategists appear to not only evaluate and make sense of the broad principles of strategy goals, but they are also engaged in ongoing sensemaking around what en route decisions emerge as change progresses.

Under umbrella conditions, there are a series of ongoing evaluations and judgements being made on new emergent decisions in parallel to those which were deliberate and initially pre-planned, suggesting a continuous process of "cognitive reorientation" (Gioia & Chittipeddi, 1991: p363) characterizes middle managers thinking practices throughout this type of approach to managing strategic change.

(TP4): *'Speculation about fellow strategists' activities'*

Community Health and Hospital Health managers believed that their reliance on anecdotal evidence about peripheral strategizing activity taking place elsewhere was not going to help improve their understanding of how Goals 1 and 3 were progressing. There were no performance indicators for them to refer to distinguish if others emergent strategizing activity was based on planned directives from top management or else based on local innovations. The intangibility of success, and how they would be able to gauge the effectiveness of fellow middle manager strategists' en route activity, left them somewhat perplexed. Hence, they also conferred low cognitive legitimacy upon Goals 1 and 3 respectively.

The central point that these managers were making was: 'how can I evaluate what fellow strategists are doing in other peripheries of the organization, when I don't know what it is that they are *expected* to be doing?' Hospital Health managers expressed similar views ('*how the dickens am I to know what they are doing?'*). Both groups argued that top management may

be able to take a 'helicopter view' of the strategy as it was developed en route, but from a middle manager perspective, they would be unable to do likewise.

What umbrella strategies appear to influence is the depth of understanding and scope for evaluation on offer to top managers who are based at the centre of the organization, in comparison to middle managers working in strategy subsystems on the periphery of the organization (Regner, 2003; Quinn, 1980). This suggests that proximity factors play a role in determining how managers at different levels of the organization view strategic issues differently and make sense of umbrella strategies as they are developed and implemented (Ireland et al, 1989). *Where* managers are situated in their organization throughout the course of the umbrella process determines their capacity to confidently evaluate ongoing emergent activity.

Autonomous subsystems are a feature of umbrella approaches (Quinn, 1980; Villa & Canales, 2008). However, if these subsystems are not connected in some way, or there is a gap or time lag en route around what has changed in one area of the system that affects another, this appears to induce low cognitive legitimacy, and gives rise to speculation about others activities within the system and the reasons underpinning any new developments or en route decisions.

(TP5): *'Moderating notions of success'*

At T3, many middle manager strategists noticeably became strongly revisionist in their outlook of the addictions strategy to the extent that they focused on process deficits instead of success performance indicators i.e. what has *"not been crystallized"* and what remains *"murky"* as opposed to what may been achieved. More attention was paid towards what was *not* done in comparison to what *was* done. Greater emphasis was placed on what had gone wrong rather than what had gone well. Many complained that there was no template or reference point for them to objectively judge whether ongoing activities were consistent or not with what top management had initially espoused, and hence, they could not accurately evaluate what aspects of the strategy had actually succeeded.

For example, Hospital Health managers arguably had a lot to celebrate. Alcohol services were no longer *"the poor relation,"* and the alcohol part of the addiction strategy was publicly acknowledged by top management as the successful aspect of the integrated strategy. However, when the strategy had not accommodated the complex co-morbid group of patients,

then its success was minimized and downplayed by Hospital Health managers and CAT nurses. Instead, they showed a tendency to maximize and emphasize the negative, namely, what had *not* been achieved rather than what had. These managers consistently presented a 'glass is half-full' outlook upon Goal 3.

This was also the case with HCO CAT managers. They acknowledged that their roles were more satisfying in the sense that nurses and social workers being co-located in the same building offered many proximity benefits such as better communication and information-sharing. However, they overwhelmingly focused on the unpleasant and negative aspects of working within their respective CATs, especially at T3 (Esyenck & Keane, 2005).

Furthermore, the strategic goals' feasibility was not discernible to Community Health and HCO CAT managers at T3, hence low cognitive legitimacy was conferred. Those involved in the methadone programme could no longer tell at what stage of their progress patients were at with the new model, and they could not see how it could ever work. In many cases, there was a notable reluctance for middle managers to accept or acknowledge that the integrated strategy had achieved anything positive at all. Optimism around what CATs could achieve over the coming months had also significantly decreased (Sutton & Kahn, 1987).

Community Health managers expressions of low attitudinal commitment were based upon the prospect of Goal 1 proceeding without their participation. They argued that the exit strategies success was impossible without their continued involvement. This was also the case with Hospital Health managers in relation to Goal 3. This suggests that when middle managers believe that their co-optation or 'participation rights' are tenuous or compromised, then their support for the strategy process is adversely affected. Such views reflect procedural justice perspectives about how participation in the strategy process influences strategists' forecasts and predictions about its likely success (Korsgaard et al, 1995; Lines, 2007).

(TP6): *'Propensity towards forecasts of disaster due to not enough planning'*

Many middle managers conferred low cognitive legitimacy, low moral (*procedural*) legitimacy, and low attitudinal commitment, at different stages of the process on the basis that there was little information or guidance from top management. Ultimately, the views of Joe and Margaret at T1 that both parent organizations were promoting the strategy prematurely without having first having established internal operational plans were soon realized by other middle managers. Initial hopes were soon replaced by general foreboding

and gloomy predictions of the future. Expectations had lowered and there was a marked shift towards pessimism with strong misgivings about the strategies' longer-term success.

As strategic goals were delegitimized on procedural and structural grounds, the potential negative outcomes of emergent activity were emphasized over the positive. At such times, middle manager's showed a propensity to forecast disaster. There was a tendency to view the present and future challenges of both parent organizations in a catastrophic fashion. These predictions tended to occur when specific details about development and implementation were not forthcoming from top management (Fiske & Taylor, 1991; Hodgkinson & Sparrow, 2002).

For example, Hospital Health managers warned at T1 that patients wouldn't use the new integrated access system to alcohol services via Social Work services. Community Health managers consistently predicted at T2 and T3 that the CATs *"wouldn't be able to cope"* without with Shared Care GP's long-term input, while HCO CAT managers argued that *"it was going to take some sort of crisis for things to get addressed properly."*

A significant increase in the prevalence of catastrophic narratives was observed from a greater number of strategists from T1 to T3. A collective narrative emerged that the addictions service was on the brink of collapse. Phrases such as *"it's a disaster,"* and *"things will only get worse,"* were used to describe the ongoing problems that the addictions service was facing. Such phrases dominated T3 narratives especially. In many ways, the addiction service was latterly perceived by the majority of middle managers to have begun operating in 'crisis-mode' (Reed & Buckley, 1988).

This appears to be problematic when emergent approaches are inconsistent with the normative and cultural expectations of some professional groups who see planning as an important structurally-legitimate component of the strategic management process (as was the case of Hospital Health managers) (Suchman, 1995). This factor appeared to be linked to the lack of confidence that strategists showed during the umbrella process, where greater emphasis was perceived to be placed on the emergent aspects of the process than the planned (Miller et al, 2004).

(DP7[53]) *'Discursive reconstruction of umbrella strategizing'*

How the deliberately-emergent strategy was conceptualized by middle managers at T1 shifted by T3. Initially, there were competing ways in which the umbrella approach was understood and accepted (Laine & Vaara, 2007). However, for the most part, the umbrella approach was viewed critically and cynically. Significant disillusionment was evident around the espoused promises of top management coming to fruition, and many were reticent and sceptical about the future success of the deliberate aspects of the strategy. Many accusations of *"mismanagement"* were aimed at top management because the process had been *"ill thought out"* and *"haphazard."* Emergent decisions of top management were delegitimized on procedural and structural grounds (Suchman, 1995), and were perceived and discredited as *"the latest fad."*

Quinn (1980) argues that deliberately-emergent approaches are "purposeful" and "proactive" (p12). However, this is not how they are always perceived by middle managers. When there is no clarity of direction for middle managers, they appear to delegitimize the umbrella process by labelling it as *"strategizing on a whim," "strategizing on the hoof,"* or *"letting the horse bolt the stable too soon."* Interestingly, many referred to the umbrella strategy one year on in foetal terms (i.e. *"the very early stages,"* and *"we are only just at the start,"* and *"a lot of nuts have yet to be cracked"* etc).

8.2.2 Control, discretion, and autonomy

(DP8): *'Drawing upon normative institutional influences to justify their actions'*

Whittington (2006: p627) has suggested that what strategists do can be influenced by *"stuff that comes from outside as well as within organizations"* (p627). What is significant about the data that emerges from this case study is that is demonstrates how Community Health middle manager strategists drew upon normative institutional influences as justification for their reluctance to engage in en route strategizing, instead of acquiescing to the demands of their parent organization by accepting the enhanced payment fee that was going to be anything less than what had been agreed at national level by the BMA.

GPs were noticed to be simultaneously coupling and decoupling themselves from their professional representative body (Orton & Weick, 1990). On the one hand, they were keen to

[53] Discursive practices

highlight that they were not acting illegally, but receiving legal guidance from the BMA, *"who the government itself recognizes as a legit professional body."* They were keen to emphasize how their non-compliance was based on professional legal guidance. On the other, they argued that the BMA's position on the enhanced services payment issue compromised their ability to proactively engage in developing the exit strategy by accepting a lesser fee. They argued that they were constrained by normative expectations and obligations, and hence, *"their hands were tied."*

Consistent with their external-orientated concerns about the new CAT model were GPs discursive attempts at broadening the argument towards outside of the organization in two ways. First, they justified their reluctance to commit to Goal 1 on the grounds that agreeing to accept anything less than the nationally agreed fee of £350 had profound implications for the GP contract on a far larger scale outside of Glasgow. Namely, that other Health Boards' executives would start bargaining with local GPs on the grounds that a precedent had been set in Glasgow.

Were GP's to prescribe methadone in Glasgow for a fee less than what had already been negotiated for *all* GPs across the UK then it would undermine their fellow medical colleagues elsewhere. Consenting to NHSGG top management demands equated to *"breaking ranks"* with the rest of their BMA members. On a pragmatic level, it was not in their interests to do so and be tarnished as *"the guys from Glasgow who sold their medical colleagues down the river."* In these terms, this justified their attempt at holding top management to ransom, and potentially *"sinking the CATs."*

(BP9[54]): *'Deploying counteracting control tactics' ('we'll decide what happens, not them')*

As Community Health managers began collectively analyzing the wider implications of acquiescing to NHSGG's demands that they accept a lesser fee for prescribing methadone, other middle manager strategists began witnessing a very bitter conflict with top management being played out in public whereby punitive tactics were deployed by both sides.

Top managements' decision to assert greater control over GP's activities by 'capping' the number of patients that [Shared Care] GP's prescribed methadone for, was not only an attempt at controlling prescribing costs, but also appeared to be aimed at penalizing GP's for their perceived lack of co-operation.

[54] Behavioural practice ('BP')

Capping meant limiting the increased revenues GP's would earn due to enhanced services fee costs increasing from £150, to the temporary fee of £350, which top management unwillingly agreed to. They believed that GP's had little incentive to move their patients on or discharge them from Shared Care clinics, as they now had greater financial incentive to hang on to them. However, they could reduce incurring more costs by allowing Shared Care GP's to prescribe for more patients.

Consequently, GP's responded to these capping measures by signalling low behavioural commitment. Top management's attempt at controlling their prescribing patterns, and curtailing their revenues, resulted in GP's consciously mounting pressures on the new system. As they were prevented from proactively participating in the development process, then they were under *"no obligation"* to comply with the supporting activities required to support it.

Instead, they decided to deploy a number of counter-acting tactics in retaliation to top managements' capping measures. This involved attempts to dictate how increased capacity could be managed by the CATs by GPs "*sending all their patients along to the CATs to deal with,"* as opposed to dealing their patients addiction-related needs as they would normally have done. Such action only worsened CAT's problems, and placed them under increasing pressure than they were already under, having no recognized prescribers. In addition, Community Health managers also began issuing threats that they were prepared to withdraw their all general medical services for existing patients whose methadone was prescribed via CATs.

There is evidence here of GP's demonstrating their 'practical evaluative agency' (Jarzabkowski, 2005; p34), by recognizing that top management were dependent on their specialist clinical skills to help resolve Glasgow's drug problem. They were conscious of the importance of their social role in addressing a major public health problem like IV drug misuse in the most socially deprived areas of the city. Top management could not compromise doctors' clinical autonomy and discretion in terms of influencing how many patients they could discharge from their Shared Care clinics, as it was only GP's who could decide which patients, if any, they would discharge from their clinics. Their clinical judgement could not be openly challenged by top management.

GPs were aware of the degree of influence that they held over the success of Goal 1. The resource-dependent nature of their relationship with their 'contractor' employer offered them leverage and scope for manoeuvre (Dowling & Pfeffer, 1975). For example, should they

decide to stop treating IV drug misuse patients and subsequently contribute to a public health crisis, they would still be needed, and contracted, by NHSGG to provide general medical and other types of enhanced services to the rest of Glasgow's population. Withdrawing from the methadone programme was not going to be too critical to their own business survival.

Not only did GPs collectively agree to exercise their managerial agency and decide to worsen capacity management issues for CATs in the interim, but they openly acknowledged that their actions could *"completely scupper the CATs."* Such an outcome was not wholly unacceptable to them, if it meant preserving the principles of the national contract agreement. *"Sinking the CATs"* was not out of the question for GP's.

Quinn (1980) has argued that umbrella approaches are politically useful and effective ways of managing strategic change, and "characteristic of good management practices" (pix). As highlighted in Chapter 2 (Section 2.3), there are, undoubtedly, many political and practical benefits of participation and involvement (Oswald et al, 1994; Rapert et al, 2002; Sagie & Koslowsky, 2000; Swanberg-O'Connor, 1995).

However, this does not mean that umbrella strategies can be less politically-charged and conflict-free because of the use of co-optation tactics, or by top management providing the flexibility for others to participate in developing the finer details en route (Chakravarthy & Garguilo, 1998). Indeed, they can create the opposite effect also. When top management vetoes the participation of a particular group of middle managers, it can lead to all-out conflict that result in strategy "dissidents" (cf. Quinn, 1980: p119) becoming arguably more disruptive than keeping them directly involved in the development and implementation process.

This data illustrates that middle and top levels of management can become embroiled in *"a game of political football"* as they both seek to gain or regain control of the umbrella strategy process. The impact of these types of en route conflict can ultimately prove detrimental to the intended strategy overall. By T3, relations between Community Health managers and top management were so severely damaged that study participants described the prospect of any reconciliation, or the payment dispute being amicably resolved, as very unlikely. This particular game of political football ended as a 'no-score-draw' with neither side walking off the park victorious, and suggests that the use of umbrella strategies as a means of building commitment and fostering legitimacy are perhaps not the universal panacea to resolving the

power-control dynamics that so often feature during the process of change (Ezzamel et al 2005). Umbrella strategies also bring with them their own unique political challenges.

As processual researchers have shown, planned actions can often drift and get lost en route as managers progressively lose sight of them (Johnson, 1992; Mintzberg et al, 2009). Similarly, this research demonstrates how emergent issues can overtake what was originally planned then subsequently dominate the strategic change process (Balogun & Johnson, 1998). Unplanned issues, such as the GP contract, took precedence over the original strategic objective to have GPs closely involved in the change process. Indeed, some practitioner accounts suggest that what really affected the umbrella process were emerging political factors and less so the lack of deliberate planning at the start of the process.

Power-control dynamics appear to play a critical role in how middle and top management actors interact in umbrella contexts. Such dynamics featured heavily in this case study, mainly in terms of how both groups attempt to retain control of the emergent process. What characterized the implementation of this particular umbrella strategy were the presence of competing agendas, and the use of both overt and covert tactics by both groups as a means of influencing the strategy process. These agendas can sideline what top management had espoused at the outset, and they emerge despite the arguments put forward for the 'political usefulness' of umbrella strategies (Quinn, 1980).

(TP10): *'Exploiting planning gaps as opportunities'*

The main theme of Specialist Health managers' T1 narratives centred on how they managed the ambiguity attached to the broad principle of Goal 1. In sharp contrast to the way in which Goal 1 was perceived by the Community Health group, Specialist Health managers responded quite differently by conferring high cognitive legitimacy to the exit strategy.

The lack of clarity was not interpreted as a *"leap into the unknown,"* but instead an *"opportunity"* upon which they could capitalize. They saw the *"disorganization"* and lack of detailed planning as providing scope for them to shape the strategy goals' development in such a way to best suit the interest of their own departments. Their narratives' described how they actively searched for *"loopholes"* within the unplanned elements of the CAT strategy document. By acting in this way helped them resolve the initial degree of ambiguity that they faced when top management failed to provide for them more explicit details during early communication exercises.

This particular example shows how middle managers can interpret, and re-interpret, ambiguity in a highly calculated fashion, and not purely from a position of disorientation or confusion as was the case with Community Health managers. They proactively look for ways to resolve ambiguity in ways that benefit their respective departments. Broad deliberate goals, and lack of detailed planning, are open to manipulation in ways that exacerbate existing problems, or else create new ones. By exploiting poor specificity and ambiguity in this way, Specialist Service managers sought to quickly influence and shape the direction of emergent activity with pragmatic self-interested motives and hence gain greater control over the emergent elements of the strategy (Caldwell, 2006; Emirbayer & Mische, 1998).

(TP11): *'Fears of exploitation and expressions of vulnerability'*

At T1, Hospital Health managers were aware that they would lose their autonomy by being pulled into an integrated service structure. They forecasted that they would end up carrying the burden of the alcohol-related workload. Opening up the referral pathways to a wider group of agencies other than GPs and senior medical colleagues was interpreted as a major threat to how much control they held over the types of patients they were required to treat. The new arrangements meant they would no longer be in a position to refuse patients, and they would lose the discretion to do so.

Hospital Health managers argued that if top management wished to take away *"the lines of demarcation"* that were in place then they required proposing what they would replace these with. As top management could not be specific, or specific enough, nor offer an alternative service structure with any detail or evidence that Goal 3 relating to the co-morbid group would actually work, Hospital Health managers subsequently conferred low cognitive legitimacy.

Social Work HCO CAT managers also expressed similar concerns that their health colleagues were already beginning to *"pass the buck"* on to them by T1 with many cases now being routinely referred on in a way that had not been done before. The lack of firm control mechanisms being in place was noted to create considerable anxiety across these middle manager groups. Despite general support for the umbrella approach, these groups were not confident in top managements' ability to ensure that sufficient control mechanisms would be put in place to protect their sense of vulnerability (Poole 1989).

Such fears may be construed as indicative of middle manager's resistance to change (Bovey & Hede, 2001; Coch & French, 1948; Oreg, 2003). However, these managerial groups held valid and legitimate concerns as their perceptions were based on past and present experiences (Balogun et al, 2007; Weick, 1995).

(DP12): *'Making a U-turn from advocating low formalization to calls for high formalization'*

Despite their preference towards low specificity around the broad principle of Goal 1 at T1, Specialist Service managers began calling for high formalization of working arrangements, and for top management to issue edicts in relation to where complex cases should be managed (Nutt, 1989). They initially legitimized the 'unplanned' elements of Goal 1 at T1 on pragmatic (*exchange*) legitimacy grounds, to now delegitimizing these same elements on moral (*procedural*) grounds by T2. Their position had now reversed from lauding the degree of flexibility that the umbrella approach allowed them, to now arguing that there was not enough planning and too much dependence on emergent and unplanned strategizing.

Their arguments changed in response to their perceived loss of control and limited influence on the change process. This followed the realization by T2 that they could not *"aggressively transfer"* their clients into CATs if there were no doctors to prescribe methadone for them. Furthermore, HAT managers found themselves engaging in a series of discursive struggles over the definition of 'homelessness' and now wanted top management to establish greater clarity over where this client group should be managed as it had become an irresolvable problem. The *"loopholes"* and *"opportunities"* were no longer available for them to exploit, and although they initially acted as advocates of low formalization at T1 they began calling for a more robust planning process in order that their concerns could be formally addressed and that less flexibility be given to CAT managers.

The data suggests that some middle managers' justifications for supporting low formalization can be linked to their ability to maximise their own personal or group benefits from such flexibility. Their discursive practices appear to be influenced by how much scope there is for them to exercise agency under umbrella conditions, and arguments in support of flexibility can alter throughout the change process depending on how different strategic groups benefit.

Specialist Service managers stance on this issue appeared to be "based on a very shrewd appreciation of the personal consequences" (Whittington, 2001: p114) that the umbrella

approach held for them. This agentic perspective would appear to best represent why Specialist Service managers were no longer such enthusiastic advocates of low formalization and sudden proponents of high formalization and planning.

Top management intervention was called for by Specialist Service managers in order to formalize Goal 1. This form of vertical deferment could perhaps be interpreted as Specialist Service manager's suddenly experiencing an epiphanic shift towards the principles of the planning and design schools of strategy (Ansoff, 1965; Chandler, 1962; Lorange, 1980). However, it became clear that their calls for high formalization were in fact acts of political lobbying in order that they could shape the development of Goal 1 more so than previous (Pfeffer, 2002). *"Who shouts the loudest"* was found to determine which issues top management were prepared to address en route, and this type of politically lobbying was shown to be an effective tactic for Specialist Service managers (Bate et al, 2000).

Overall, calls for greater formalization and planning can be politically-driven, and do not necessarily reflect managerial preferences about how managing strategic change *"should be done."* Middle managers appear to advocate the generalities of the broad principles when it best serves their own interests at different stages of the change process.

(DP13): *'Discursive resetting of the boundaries en route'*

Following the issuing of an edict by top management as to what constituted 'homelessness' and how it should be defined, problems continued between the HAT and CATs around who should be accepting the care and responsibility for homelessness clients.

The 'Homeless Interface Protocol' specified which agency would be responsible for these clients at different stages of their treatment, but even though it was now written in black and white how this client group should be managed, CAT managers refused to acknowledge top managements' edict, and they developed their own acceptance criteria for those referrals that the HAT attempted to refer on to CATs.

Eisenhardt & Sull (2004) have argued that using 'simple rules' to dictate strategic activity supports successful change. However, regardless of the simplicity, explicitness, and unambiguousness of such rules or edicts, middle managers still show the capacity 'to do otherwise' (Giddens, 1991). In this case, the meaning of homelessness was interpreted and re-interpreted, and acted as a discursive mechanism that prevented CAT managers accepting any homelessness-related referrals. Despite top managements' edicts which set out the boundaries

as to where homelessness cases should be managed, CAT managers still *"bounced"* these referrals in order that they did not take any responsibility for new cases.

Laine & Vaara (2007) have shown how middle managers can initiate unit-specific strategy discourse to create room for manoeuvre in situations where their development activities are not supported by top managements' discourse. This is certainly true of this case example where middle managers operate under umbrella conditions, as edicts are still "subject to varied interpretations" (Mintzberg & Waters, 1985: p263).

(TP14): *'Calculated activity'*

What was clear from the narratives of those middle managers who were vertically co-opted into the umbrella strategy process is that they appear to face tensions around their role as strategists i.e. they are required to choose what to tell others and what not to tell. Joe talked of *"juggling acts"* and *"what to talk about with the team when there are rumours flying about."* Margaret spoke of *"the confidential nature"* of discussions and not disclosing what new arrangements were being considered while also becoming *"a wee bit more politically aware"* and the consequences of sharing this information with her team members. This distinguished them from their horizontally co-opted colleagues who did not face such issues.

The activities of Joe and Margaret were also more calculative (in a proactive sense), than their horizontally co-opted colleagues who were found to act more reactively to top management demands and system pressures. Joe described being conscious of having been handed *"a blank canvas"* and being in the position to decide *"when to pull the reigns in,"* while Margaret talked of the *"informality"* of the umbrella process and having the discretion about what issues to *"run past"* the top management team.

Although Rouleau (2005) has illustrated that middle managers acts as 'sellers' of change, they can also decide 'not to sell' or say anything at all about forthcoming proposals or impending or future developments. Indeed, Joe and Margaret began to sell change on a highly selective basis. Both acknowledged their scope to sell change in this way on a discretionary basis (Jarzabkowski, 2005).

(BP15): *'Calculated inactivity'*

This practice was observed in two ways: restrained silence and experimentation-averse behaviours. What is important to note of these two practices is that both Joe and Margaret

were conscious of the scope they held 'to say nothing,' as well as 'holding back' from the developing and implementing strategy goals en route (Bourdeau, 1990; Mantere, 2007).

'Restrained silence'

Joe and Margaret developed defensive routines instead of voicing their concerns to top management colleagues (Argyris, 1989). For example, both of them believed that they could not publicly voice their concerns about the lack of planning that had taken place prior to T1, but that they did not make known their concerns to top management that *"the floodgates may open,"* or that *"the horse had bolted the stable too soon."* Joe also made it clear that public resistance to the new CAT model was not a feasible option for him.

Joe and Margaret also believed that they withheld their views at T1 in the event that they were perceived as being critical (Milliken et al, 2003). Ashford et al's (1998) research on impression management concluded that employees decide whether to raise strategic issues with top management by 'reading the context' for clues concerning 'context favourability'. The context for Joe and Margaret was certainly not favourable because from period T1-T2, the top management team was a temporary team until the recruitment and selection of the permanent top management team was confirmed. During this period, they confided to the researcher that it was *"difficult to know who to trust."*

When middle managers hold a recognized strategist role (Jarzabkowski et al, 2007), and find themselves being required to engage in strategic activity that conflicts with their personal and professional interests (Turnbull, 2001), some 'toe the party line' while others pursue top managements' agenda instead of expressing their concerns about such activities in public. This data supports Giangreco & Peccei's (2005) argument that middle managers cannot easily reject changes in public. In the case of Joe and Margaret, it held personal career consequences for both of them as they were both seeking permanent contracts.

'Experimentation-averse behaviours'

By T3, Margaret no longer experimented with new ideas or encouraged innovation in the NE CAT due to the social costs of failing i.e. *"rocking the boat"* and *"fear of bad publicity."* Margaret also reported her team members had become pre-occupied about *"the shit hitting the fan"* etc, and developing risk-averse attitudes. Joe disclosed at T3 that he consciously *"held back"* from encouraging experimentation within his team until the GP contract issue was resolved, and until he was confirmed as the permanent manager of the East CAT.

A characteristic of emergent strategizing is an organization's capacity to experiment (Mintzberg et al, 2009: p199), and especially so of logical incrementalist approaches where risk-taking attitudes are actively encouraged (Quinn, 1980). Arguably, umbrella strategies are less likely to succeed where key strategic actors become inhibited towards testing out new ideas, and when organizational environments become less conducive to creativity and experimentation due to inertia.

Middle managers require the opportunity to experiment with new ideas to develop strategy goals en route. When there are *"no fresh ideas and no impetus"* as was this case in this study, then umbrella strategies are perhaps more to likely move towards a state of inertia (Eden & Ackermann, 1998). In umbrella contexts, middle managers not only require adopting interpretative and selling roles (Balogun, 2003; Rouleau, 2005), but also one which requires creativity and experimentation to flesh out the broad principles of strategy goals.

The findings of this study indicate that middle managers must be afforded the scope and flexibility to do this, instead of being discouraged by public criticism and risk-averse attitudes in their organization. The wider public consequences of error's, or 'speaking out', can be detrimental to the credibility and personal legitimacy of middle managers to the extent that they become reluctant and unwilling to experiment, or disinclined to continue engaging in emergent strategizing. This requires some acceptance from top management that there are aspects of en route strategizing that are more about trial and error than meeting performance objectives.

(BP16): *'Emotional masking'*

Horizontally co-opted managers described experiencing feelings of emotional distress, especially from T2 onwards. However, they did not express these feelings in public. Instead, they privately shared their anxieties and anger with each other as they did not wish to express their frustrations to those lower-level staff who they managed.

Masking their emotions in this way was their attempt at remaining constructive, positive, and motivated in the eyes of lower-level staff. Concealment of their anger, and also their own feelings of inadequacy, was maintained to uphold morale in their teams, even though the change process brought a personal emotional cost to each of them.

It appeared that these middle managers were bearing the burden of significant emotional distress in order to 'keep the strategy going' (Balogun, 2003; Huy, 2001). This practice was

arguably helpful in maintaining some degree of outward public support for the strategy even though these middle managers no longer held this inwardly. It also suggests that middle manager conform to 'display rules' (Hochschild, 1983), by upholding organizationally-desired emotions, despite the internal stress that they are themselves experiencing during change (Cooper et al, 2001).

(DP17): *'Prioritizing emotional support to lower-level staff over operational targets'*

Negative emotional responses are commonly associated with organizational change due to actors experiencing heightened uncertainty and personal loss (Mossholder et al, 2000; Sutton & Khan, 1987), feelings of resentment (O'Neill & Lenn, 1995), symptoms of stress and anxiety (Cooper et al, 2001), and difficulty in coping with changes to organizational identity (Dutton & Dukerich, 1991). All of these were characteristic of how CAT middle managers described lower-level employees' inability to adapt to the new integrated service structure.

Researchers have previously highlighted middle manager's role in emotionally supporting others through strategic change (Balogun, 2003; Huy, 2001, Sims, 2003). What is interesting about the data in this case study is that CAT middle managers were using supervision sessions as emotional support conversations and not to discuss and review the capacity management and exit strategy issues that top management had intended them to be.

Conversations that were supposed to be operational-focused were instead being used as a supportive and coping mechanism for lower-level staff by CAT middle managers. They were now acting on their own discretion by maintaining that this was how supervision sessions ought to be used. Consequently, less attention was given to reviewing cases suitable for moving out of the service, and this practice paradoxically contributed to the teams' caseload numbers becoming ever-increasing instead of lessening over time.

This finding supports arguments about the importance of individuals' and group emotions within organizational change research (Bartunek et al, 2006; Seo et al, 2004), and in particular, how their time-intensive management diverts attention away from operational matters can be consequential for change outcomes (Johnson et al, 2003; Jarzabkowski et al, 2007).

(DP18): *'Vertical deferment as acts of protest'*

Like their Specialist Service colleagues, CAT managers also deferred a number of issues back to top management by T3. However, their reasons for doing so were less politically-calculated or driven, but more out of frustration and anger that change had not unfolded as intended.

As the data-gathering period concluded at T3, CAT managers had refused to accept any more referrals for the methadone clinics, nor open up new clinics to increase capacity. They no longer carried out supervision sessions to review cases for discharge by T3, and absenteeism had significantly increased. All were deeply pessimistic about the service ever improving, and took the view that it was now up to top management to address the problems they were experiencing as they now felt *"pretty helpless."*At the core of their despondency was the view that they no longer felt capable of performing their traditional caring roles as a consequence of the capacity management issues that had dogged the new integrated service.

Rousseau (1998) has argued that for organizational members to adapt to change, they have to feel that their self-identity is not threatened. Yet, *"playing the numbers game even more so than before"* had become threatening to the degree that almost all CAT managers had made the decision to leave their respective teams in order to preserve and enhance their professional identities elsewhere (O'Doherty & Wilmott, 2001), as *"enough was enough."*

8.2.3 Co-optation, participation, and involvement

(DP19): *'Making accommodations to help problem solve'*

There are a number of examples where middle manager groups demonstrate a degree of flexibility as change was being implemented by socially negotiating ways to help CATs cope with their problems. For example, horizontally co-opted managers in both CATs were prepared to persist with increased methadone clinic numbers until the GP contract was resolved, in spite of the numerous difficulties they were facing by T2. Specialist Service managers were also prepared to retain clients in their own services (e.g. those who were no longer homeless or pregnant) to temporarily alleviate the capacity management problems that East and NE CATs were facing.

Such accommodations conflict with the view that middle managers only offer a negative contribution to implementing change, and that they tend to act in ways that will derail the process (Connors & Romberg, 1991; Guth & McMillan, 1986, Meyer, 2006). It is clear from these examples that they are not always the 'roadblocks to change' that some researchers have depicted them (Graetz, 2000). It is when their flexibility and goodwill is stretched to the point that their own functions can't be fulfilled anymore, that arguments about their intransigence and self-interested motives can perhaps be considered more fully.

(BP20): *'Reversal of public commitment to the strategy'*

The behavioural view of commitment contends that individuals act in a consistent manner and are bound to actions that become publicly irrevocable. Such actions constrain future choices, and are not easily reversible (Keisler, 1971a; Salancik, 1971a). However, the public irrevocability arguments do not appear to be quite so universal when applied in umbrella strategy contexts. Many strategists were found to say and do one thing at a certain stage of the process, only for them to publicly change their stance on the same issue at another stage. Two examples illustrate this practice.

First, both Joe and Margaret were firmly committed to the principles of Goal 2 at T1, but were not so committed to these by T2. Despite being public advocates for the middle manager cause (e.g. *"it's top of our agenda"*), they began adopting less of an advocacy role and talked less of *"the quality-based approach"* that they had initially supported and repeatedly emphasized.

Joe and Margaret had no great difficulty revoking their commitment to Goal 2, despite the unpopularity of doing so coming from within their respective teams. Although they conferred high moral legitimacy upon Goal at T1, in its variant form of *consequential legitimacy*, the potential problem of retaining their managers had become less of a concern to them. Instead, the issue of resolving their own personal contractual issues and being offered their positions on a permanent basis appeared to have taken precedence over their initial plans for developing their managers, as well as the methadone programme exit strategy.

Furthermore, Joe had publicly stated during communication exercises with staff that he intended to network across organizational boundaries to resolve operational problems, but then confided to the researcher that he had no intention of doing so until the GP contract issue had been resolved.

By conferring high pragmatic legitimacy upon Goal 2 at T2, in its variant form of *exchange legitimacy*, suggests that exchange factors outweighed their public commitment to Goal 2 over the consequences for others. Hence, why their commitment shifted in ways that they did not feel obligated or bound to.

Second, Hospital Health managers were adamant that they would not co-operate with CATs by sending their patients to GCC Social Work locations, yet by T2 and T3, they were more than happy to do so. In the case of Hospital Health managers, their reversal was a positive one, as they were now actively promoting the use of a single point of entry into the addictions service via CATs. This was found to occur by T2 after being more closely consulted about how alcohol referrals ought to be directed within the integrated service structure. Changing their public position towards following the espoused objectives of top management were met with widespread surprise by other strategists, however, it appeared to occur due to their increased involvement and influence in the decision-making process (McFarlin & Sweeney, 2002).

In summary, it would seem that middle manager commitment is publicly irrevocable if actors self or group interests are being served or not, and that some actors have little difficulty in changing their commitment to strategic objectives during the umbrella process.

(BP21): *'Vertically co-opted strategists engaging in behind closed doors strategizing'*

The narratives of Joe and Margaret indicate that strategizing is both a public and informal private practice that does not always involve a series of organized sessions that are structured in order to work through different strategic issues. As Hoon (2007) has previously shown, strategic decisions can often be negotiated and discussed outwith planning sessions or committee meetings.

It is interesting to note that these two vertically co-opted middle managers were more likely to confer high cognitive legitimacy towards emergent decisions than their horizontally co-opted colleagues as well as Community Health managers. These groups tended to take a much more negative view towards how change was progressing by expressing low attitudinal commitment. This suggests that there are proximity benefits to being involved in strategizing behind closed doors in terms of understanding and comprehending broad complex strategic issues. However, there also appear to be some drawbacks.

Joe and Margaret reportedly became increasingly detached operationally, and this proved unhelpful to how they were perceived by their fellow managers and lower-level employees. Therefore, although it was useful for them to be involved in such high-level decision-making, it adversely affected their status and authority within their respective teams as they were more often found to be 'posted missing' (Balogun & Johnson, 2004).

(DP22): *'Mimicry of top management rhetoric by vertically co-opted middle managers'*

In parallel to their vertical co-optation and engaging in behind closed doors strategizing, Joe and Margaret noticeably changed the way in which they talked about the strategy. They derided top managements pre-occupation with 'the numbers game' at T1, yet they both became more concerned with such capacity management and financial issues by T2 and T3. This occurred to the extent that, as they confessed, the professional development of their managers and respective teams was no longer the priority for either of them, and their behavioural commitment towards Goal 2 had lessened.

When middle managers are vertically co-opted, and subsequently spend more time with top management and engage in discussions at a more senior level, then their priorities shift en route as part of the deliberate-emergent strategizing process. This appears to manifest itself in the type of language they use and the way in which they begin to talk about what are now considered strategic priorities from their own newly-formed perspective (Bowman & Ambrosini, 1997).

(TP23): *'Suspicions about the motives of vertically co-opted strategists'*

Lack of information and detail about the activities of fellow strategists gave rise to speculation occurring between different middle manager groups (see TP4). However, it was suspicion which characterized horizontally co-opted managers thinking as Joe and Margaret engaged in behind closed doors strategizing and began mimicking top management rhetoric.

The consequence of such suspicions was that Joe and Margaret no longer held the respect and personal legitimacy (Suchman, 1995) from within their teams as many believed that the teams' interests were not being represented within these closed meetings. As only limited or selective pieces of information was being imparted to them (as Joe admitted via his discursive 'juggling act'), it changed the working relationship between Joe and Margaret and their colleagues.

The conscious decision taken by these two managers to conceal details around emergent decisions ultimately proved harmful to the change process by T3 because their activities lacked transparency. Their claims of managerial paternalism were also being brought into question as they became more operationally detached.

Ultimately, Joe and Margaret were no longer perceived to be legitimate leaders of their respective teams (Meindl, 1995). This subsequently impacted on team members remaining willing to strategize on an ongoing basis. All trust was lost between vertically co-opted and horizontally co-opted middle managers in the same way researchers have noted it gets lost between top management and lower-level employees (Lines et al, 2005; Neves & Caetano, 2006).

(DP24): *'Vilification of top management and vertically co-opted strategists'*

In parallel to the change unfolding, the labels attached to top management and vertically co-opted strategists became more defamatory and filled with resentment. Community Health managers derided top management and ridiculed their sincerity about engaging them in ongoing discussions about creating the exit strategy.

Specialist Service and Hospital Health were equally unflattering to the extent that there were calls for punitive action to be taken against top management. However, it was the depictions of *"sweet-talking Joe"* and *"ambitious Margaret"* who was *"on tour"* that had become particularly hostile. This markedly changed over the course of the change process.

(DP25): *'Emergence of tragic narrative styles'*

By T3, there was a noticeable change in middle managers narrative styles. For example, Community Health managers now talked in a less combative tone, and they no longer continued to use war metaphors such as *"getting behind the barricades"* etc as they had done at T2. In contrast to their cautious outlook at T1, they were now weary of the ongoing battle over the enhanced services payment issue, and that *"the chaos"* surrounding the methadone programme over the course of the last year had been *"bad for morale"* and *"disheartening"*. They appeared less willing to fight it out with top management, and relinquished their earlier battling talk.

Instead, they offered an account of change in a tragic narrative form (Beech, 2000) by referring to *"the downfall of the CATs"* and how financial issues seemed to matter more than

"the gold standard of care" that they had identified themselves with. Similarly, horizontally co-opted managers began talking of *"losing the battle,"* and referred to their teams being akin to *"the Marie Celeste,"* by depicting scenes where lower-level staff had deserted them and given up.

As middle managers become fatigued by the challenges they face as part of the umbrella process, this is reflected in their discourse where change unfolds unsuccessfully.

(BP26): *'Withdrawal and opting out'*

Jarzabkowski et al (2007) have raised the issue of 'who can be considered a strategist?' as an important issue for strategy-as-practice researchers. Initially, this appeared dependent upon who top management decided to co-opt into the strategy process, and which members of the organization were granted 'participation rights'. Some middle managers were pro-actively co-opted into the process, and responsibility was deferred to them to develop the finer details of strategy goals en route.

In contrast, top management excluded non-conforming Community Health managers as change proceeded, and this subsequently had an adverse impact on Goal 1. In this respect, it may seem that the matter of 'who is in' and 'who is out' is solely at the discretion of top management, and that co-optation is purely on an invitational basis from top management.

However, co-opted strategists can also exercise their choice to opt-out of the process. Therefore, determining strategy group membership is not the exclusive domain of top management, as some middle manager strategists choose to opt-out of their own volition be it through protest (horizontally co-opted managers), fatigue (Margaret), or apathy (Community Health and Hospital Health managers) – all of which were signs of low behavioural and attitudinal commitment.

This suggests that there are limitations to co-optation in that middle managers may be purposely co-opted into the strategy process, but they cannot always be expected to remain as strategy participants' throughout the development and implementation period. There is no guarantee they will wish to remain involved, especially if they believe there is a lack of clarity and direction from top management. Indeed, as this case study shows, many could no longer be persuaded to remain engaged in developing strategy goals, and a number of middle managers actively disengaged altogether.

The data shows that co-opted membership in umbrella strategizing appears to be dynamic and fluent. Different strategic actors appear and depart from the strategy process at different time periods. Some actors are ever-present on stage, and some have frequent walk-on parts, while others make only a fleeting cameo appearance.

8.3 Middle manager practices and change outcomes

A third aim of this thesis was to examine how middle manager practices which emerge during umbrella strategies are consequential for change outcomes (Jarzabkowski et al, 2007). Of specific interest, were the outcomes of strategic change when both deliberate planning and emergent participative approaches are used in chorus, and what it is that middle managers are doing as part of this process which influences outcomes.

How middle manager's interpreted and made sense of change, how they discursively justified their positions on it, and why appeared to do certain things, provide some explanations for the strategies' intermediate successes, but mostly its subsequent failure. Many discrepancies emerged between the explicitly-stated and deliberately-planned aspects of the strategy and the emergent discretionary practices that middle managers enacted as they 'worked on the finer details' of the umbrella strategy enroute. Sub-group interpretations of the deliberate plan, as well as discrete judgements being enacted of what action required to be taken en route, were frequently found to be inconsistent with the espoused change targets from top management.

Although a few discretionary middle managers practices supported the development of the strategy that top management intended (e.g. making accommodations to problem solve, promotion of intended goals following co-optation, mimicry of top management rhetoric by vertically co-opted managers), the data findings provide many examples of where middle manager's practices led to negative unanticipated outcomes, and where they appeared to act in ways that were counter-productive to the broad principles of the espoused strategy at firm level (e.g. calculated inactivity, reversal of public commitment to the strategy, vertical deferment as acts of protest etc).

It is tempting to construe middle manager practices as "obstructive" in the same way that other researchers have done previously (Connors & Romberg, 1991: p61; Guth & McMillan, 1986, Meyer, 2006). However, based on the data from this case study that provides justifications, rationales, and explanations for what middle managers were doing in practice

as they attempted to develop the finer details of the umbrella strategy, it would be over-simplistic to accuse middle managers as being solely culpable for the strategy failing as it did. To merely dismiss middle manager strategists as obstructive without taking cognisance of the strategic, institutional, and organizational contexts in which they attempt to strategize is unhelpful to better understanding what they do that produces unintended outcomes.

From a strategic context, umbrella approaches appear to provide scope for middle managers to exercise managerial agency in ways that robustly designed deliberately-planned strategies do not. Therefore, it is questionable whether top management teams can accuse middle managers of acting improperly or without sincerity when it is they who grant them such autonomy in the first place, as well as formally afford them the opportunity to exercise choice to develop the finer details enroute.

Furthermore, where there is high ambiguity around broad strategic goals, agentic practices of middle managers subsequently 'fill the void' that the underdeveloped or unplanned aspects of the strategy have left. This response is perhaps not so surprising when top management are less accessible for guidance, or where vertically co-opted (VCO) managers become more engaged in behind-closed-doors strategizing to the extent that fellow strategists take matters into their own hands and make an attempt at resolving the ambiguities they face on a day-to-day basis. Top management and VCO's loss of control and interest arguably allowed many discretionary practices that were inconsistent with the espoused change targets to emerge and go unnoticed.

What is important to note is that there was never at any point throughout T1, T2, or T3 any indication that each of the middle manager groups set out to be intentionally destructive and derail the strategy process in a premeditated fashion. For example, Specialist Service managers claimed no wrong-doing for their decision to immediately transfer clients into CATs by arguing such a step was the catalyst to moving individuals towards full rehabilitation and exiting the addiction services as planned. They maintained that top management had shown them *"the green light"* by calling for their input and involvement to start and find ways to implement the exit strategy. In this instance, the umbrella approach was directly cited as has having created the conditions that allowed them to *"exploit the gaps"*.

It is difficult to foresee how middle managers will respond to the generalities of broad strategy goals, as their interpretations can subsequently shape emergent activity in ways that

prove counter-productive to the strategy's aims. This factor was arguably underestimated by NHSGG and GCC's top management.

From an institutional context, the strategy faced major problems because of the position of Glasgow's GPs. Their affiliation to their own professional body took priority over their sense of obligation towards their contractor or employing organization. This is not a new observation, as conflict between the legitimacy of change targets and actor's institutional requirements on a normative level often finds them adhering to normative standards (Kelman, 2001; Scott, 2001). However, it is the consequence of such loyalty that has implications for change outcomes. In this case study, it influenced Community Health manager's compliance with the demands of top management to the extent that Goal 1 was never successfully developed and implemented.

Community Health & Specialist Service managers also began making reference to published clinical and social research articles that supported the efficacy of the Shared Care model, while simultaneously delegitimizing the newly-devised CAT clinic model by conferring low moral (*structural*) legitimacy on the grounds that they could see *"no clinical evidence-base for it."* Separating patients from their doctors who prescribed their methadone treatment from the doctors who provided their everyday general medical needs was interpreted as *"absolutely crazy."*

If the new CAT clinic model was supposed to underpin the direction that top management were now insistent on taking, then Glasgow's addiction services would hold no credibility in the eyes of [external] experts in the addictions field. In this sense, the content of Goal 1 failed to gain moral *(structural)* legitimacy as it was not in accord with, and in breach of, the values and beliefs of both Community Health and Specialist Service managers (Zelditch, 2001a).

Denis et al (2001, 2007) have drawn attention to the challenges that organizations face when actors belong to plural institutions. It would appear that a fundamental problem for organizations that includes multiple strategists who belong to different professional institutions is that these strategists can often fail to understand the history and the norms of other institutions to which they themselves do not belong.

It is understandable why Glasgow's GPs took the stance they did, because failing to do so meant they were at risk of ostracising and isolating themselves from their fellow doctors not just in Glasgow, but all across the UK. Yet this was never recognized or acknowledged by

other middle manager strategists. Nursing and social work middle managers failed to look at the enhanced service payment issue beyond their own institutional lens. The result of which was that GP's were often delegitimized through name-calling and negative labelling, and castigated for being a greedy, self-interested group who were considered *"a fucking nightmare"* with *"the pound signs in front of their eyes."* Constructing GPs in such a way proved harmful to the spirit of collectiveness, the ideals of collaboration, and the level of group co-operation required to support successful change.

This issue raises an important question for pluralist organizations undergoing strategic change: how much can be expected of middle manager strategists to understand and be aware of the institutional pressures that others face? It is difficult to see how a diverse group of strategic actors can begin to reconcile their differences unless their institutional differences are not publicly-known, understood, and acknowledged. This did not happen in this case of Glasgow's GPs[55].

Unless there is a high degree of professional, educational, or personal networking across pluralist organizations that inform diverse groups of strategists of the detailed and sometimes complex institutional constraints that others are acting under, then it is understandable why some strategists fail to comprehend what others are doing en route and why, and the subsequent resentment and intolerance that follows.

Another institutional factor related to the issue of whether health and social work middle managers actually saw themselves as 'strategists' at the outset (Jarzabkowski et al, 2007). By T3, there was a consistent theme in middle manager's narratives that top management were the ones responsible for the overall design and management for strategy process. A responsibility that they were considered to have failed to deliver on. The discursive practice of vilifying top management, and calls for punitive action against them, demonstrated that they were perceived to have neglected their strategic and managerial duties.

Umbrella approaches representing "real-life strategies" (Mintzberg & Waters, 1985: p263) was discussed in Chapter 3, but whether middle managers see themselves as "the architects" (Quinn, 1980: p73) that deliberately-emergent strategies require of them has implications for change outcomes. The practice of vertical deferment suggested that this may not have been

[55] At T2 and T3, the researcher was informally approached by top management team members on two occassions who encouraged the broader institutional context that helped explain what GPs were doing and why to be under-emphasized in the evaluation report. This appeared to be because it was in the political interests of NHSGG that widespread resentment towards GPs was maintained until the GP contract dispute was resolved.

the case, as middle managers being asked to adopt a strategic role (albeit enroute) was one they had not traditionally taken on before and was at times both unfamiliar and uncomfortable for some.

Public sector organizations have a long history of top-down management approaches to clinical, financial, and strategic management (Ashburner et al, 1996; Ferlie et al, 2003; Hartley et al, 2002). Lines of command and hierarchical authority are especially familiar to the medical and nursing professions (Scott, 1986). This was heavily reflected in the views of medical and nursing middle managers across Glasgow's addiction service where they expected that traditional top-down authority would also apply to the management of strategic change. It seemed taken-for-granted that top managements' role as the 'planners' and 'fixers' should remain, and that it was they who should be required to react and address any emergent development or implementation issues, and not middle managers.

It would appear that the success of umbrella approaches appears dependent on whether middle manages themselves begin to reconstruct their own identities as 'strategists' (Jarzabkowski et al, 2007), or else simply see themselves on the receiving end of change as opposed to having the capacity to shape the strategy process (Fenton-O'Creevy, 2001).

In an organizational context, NHSGG and GCC were undertaking radical second-order change which previous research has noted to be profoundly disruptive (Bartunek, 1984). In this case study, this proved to be especially so as a change in direction for both organizations was being managed using an approach which middle manager strategists were not entirely familiar with.

It is widely acknowledged with the management literature that embarking on a new way of doing things can often be a disorientating and painful process for many (Cooper et al, 2001; Mossholder et al, 2000). By T3, it was clear horizontally co-opted CAT managers were often making sometimes failing attempts at coping with the emotional impact of the challenges that umbrella strategizing presented them with. Ultimately, this proved particularly stressful for some and took an emotional toll on them to the extent they wanted to leave their jobs altogether.

Proponents of emotion-related research argue that not enough attention has previously been paid to the importance of individuals' and group emotions within organizational change research (Bartunek et al, 2006; Fisher & Ashkanasy, 2000; Oreg, 2006; Piderit, 2000). This

data supports that argument, and that a greater appreciation of middle managers' emotional experiences can help both researchers and practitioners develop a better understanding of *the doing* of umbrella strategizing (Huy, 1999; Seo et al, 2004).

The absence of a support framework to help assist middle managers once they formally become part of the umbrella strategy process raises an important ethical question around co-optation: should middle managers be co-opted and brought into the umbrella process in the first place, then delegated the responsibility to develop complex strategic goals, if the guidance of top management is not available to them en route?

If a support framework is not in place, especially in complex organizations that embark upon radical strategic change in pluralistic settings (Denis et al, 2007), that require strategists to work across organizational boundaries (Balogun et al, 2005; Huxham & Vangen, 2005), to develop and implement multiple strategic goals en route (Jarzabkowski & Sillence, 2007), and where their top management remain detached or 'invisible' from the emergent process (Balogun & Johnson, 2005), then it is argued that middle managers are being set up to fail. For middle managers to strategize by encompassing each of these factors, as was the case with the Glasgow addictions strategy, is perhaps setting unrealistic expectations about what middle managers are expected to achieve en route when an umbrella approach is adopted.

Overall, the accumulative effect of middle manager strategists' multiple divergent discretionary practices, and the complex strategic, institutional, and organizational contexts in which they were situated, helps explain why the addictions strategy produced many unintended and unanticipated outcomes.

CHAPTER 9

CONCLUSION

This chapter concludes the thesis by briefly summarizing the progression of the argument through all chapters (Murray, 2002), presenting its contribution to theory and managerial practice, and its implications for future research. Reflections on the research process are also discussed.

This thesis contributes to theory in two ways:

(i) understanding the nature of the relationship between strategy legitimacy and strategy commitment during strategic change

(ii) examining strategic change from a strategy-as-practice perspective.

9.1.1 The legitimacy and commitment relationship

This thesis offers an original contribution to strategy, legitimacy, and commitment fields of research because the strategy legitimacy-commitment ('L-C') relationship has never before been examined at a micro-level of analysis in real time (Johnson et al, 2003), using qualitative longitudinal methods (Beck & Wilson, 2001; Mowday, 1999; Suchman, 1995), from the perspective of those outside of top management teams (Balogun et al, 2007), and using actor's own narratives to describe how they confer legitimacy, and commit to, strategic change (Barry & Elmes, 1997).

It has integrated research on strategy, legitimacy, and commitment and illustrates how current conceptualizations of legitimacy and commitment are applied in different ways across strategy and management discourses. It argues that current usage of legitimacy and commitment constructs, which are employed to support claims of reciprocity, is fundamentally problematic from a discursive perspective as legitimacy and commitment are multifaceted constructs, and not one-dimensional as the strategic change literature often presents them.

In response to calls from the strategy, legitimacy, and commitment fields for researchers to provide greater conceptual clarity on legitimacy and commitment as constructs (Golsorkhi et al, forthcoming; Johnson et al, 2007; Meyer & Allen, 1997; Suchman, 1995; Vaara et al, 2006), this thesis clearly defines the concepts of *strategy legitimacy* and *strategy commitment*

as clear unambiguous constructs from which to study the 'legitimacy of strategy goals', and actors 'commitment to change'.

It reinforces the importance of conceptual clarity required when using legitimacy and commitment constructs in strategy research. This is particularly important with respect to *strategy commitment* as this research has combined strategy and change commitment discourses to address the type of conceptual problems that commitment researchers have previously highlighted (Becker et al, 1993; Meyer & Allen, 1997; Mowday et al, 1982; Reichers, 1985).

This thesis problematizes the taken-for-granted assumption within strategy and management discourses that legitimacy and commitment have a reciprocal relationship (Brown, 1998; Dess & Priem, 1995; Dooley et al, 2000), which in turn, supports successful strategic change. By exploring middle managers' strategic reasoning and sensemaking (Regner, 2003; Rouleau, 2005), it provides empirical evidence which shows that the strategy L-C relationship is more complex and less reciprocal than the normative view suggests.

Where firms adopt umbrella strategy approaches to strategic management (Mintzberg & Waters, 1985), and a wider group of strategic actors outside of top management teams are co-opted into the development and implementation process (Mantere & Vaara, 2008), the L-C relationship becomes more complicated. Some forms of strategy legitimacy can still develop despite strategy commitment not transpiring as intended (and vice versa). When examined in the context of strategic change, different legitimacy and commitment constructs produce multiple relationship-types which are reciprocal, non-reciprocal, and in some cases, both. In sum, the strategy L-C relationship cannot be considered as exclusively reciprocal as change unfolds over time.

Adopting longitudinal methods plays a critical role in determining the temporal nature of the strategy L-C relationship. Not only has this study established that these relationships are not always reciprocal, but by analyzing them over three discrete periods, has shown how they shift and fluctuate over time as change unfolds (Langley, 1999). This particular finding suggests that middle manager's legitimization of, or commitment to, strategy goals cannot be considered as stable during ongoing change.

Importantly, longitudinal approaches show how internal sources of legitimacy can be temporal in the same way as external sources of legitimacy have been found to be (Pfeffer &

Salancik, 2003; Ruef & Scott, 1998). It also answers a long-standing question of commitment researchers as to whether commitment changes over time (Beck & Wilson, 2001; Mowday, 1999). What actors commit to at one stage of the strategic change process, does not necessarily mean that they will remain committed to the same goals at another stage. In some respects, it is understandable why some researchers claim reciprocity between legitimacy and commitment, particularly if their claims are based on non-longitudinal or single data collection capture periods. However, this research was able to illustrate that although the relationship was often reciprocal at the early stages of change at T1, it became less so as time went on. By T2 and T3, non-reciprocal relationships were shown to be increasingly prevalent.

Specific contributions are made to both legitimacy and commitment-related research. By departing from traditional approaches to legitimacy research, whose dominant analytical focus has remained firmly on the legitimacy of 'the claimant' or 'the organization' (e.g. Ashford & Gibbs, 1990; Deephouse & Carter, 2005; DiMaggio & Powell, 1983; Pfeffer & Salancik, 1978), this study has shown the importance of analyzing 'the claim(s)' or strategy goal(s) (Kelman, 2001) that organizations make when determining or justifying their future direction. It is argued that this level of analysis, which is 'claim-orientated' or 'strategy goal-orientated' as opposed to 'claimant-orientated' or 'organization-orientated', is also critical for better understanding the process of managing strategic change.

This thesis reflects those concerns of legitimacy researchers who have argued that legitimacy studies too often overlook these internal sources in favour of external sources (Elsbach & Sutton, 1992; Human & Provan, 2000; Kostova & Zaheer, 1999; Kumar & Das, 2007; Ruef & Scott, 1998). It draws a distinction between [external] *organizational legitimacy* and [internal] *strategy legitimacy* as separate foci of analysis when studying legitimacy.

While is it is acknowledged that external sources of legitimacy are critical to firms in order to acquire resources from suppliers and external constituents (Dowling & Pfeffer, 1975), this research emphasizes the importance of internal sources of legitimacy when firms manage strategic change. It shows that legitimacy is not only derived from external groups as Stone & Brush (1996: p634) claim, but that it also operates, and matters, at the individual and internal level also (Kelman, 2001). It makes explicit what form of legitimacy actors confer upon strategy goals, and makes clear the distinctions between pragmatic, moral, and cognitive forms of legitimacy based on actor's narratives (Vaara et al, 2006), and addresses Suchman's

(1995) question about the inter-relationships that legitimacy variants have to each other by demonstrating how they can coexist during strategic change.

In contributing to commitment research, this study conceptualizes commitment as a bipolar construct. Based on an extensive review of the commitment literature, it identifies two distinct variants of strategy commitment: *strategy behavioural commitment* and *strategy attitudinal commitment*. By examining strategy commitment from an integrative perspective, it contributes to the emerging consensus in the commitment field that views commitment as comprising both behavioural *and* attitudinal elements (Brooks & Wallace, 2006; Herold et al, 2008; Herscovitch & Meyer, 2001; Jaros et al, 1993; Meyer & Allen, 1997; Meyer et al, 1998; Mowday, 1999; Penley & Gould, 1988).

This research also adds to the developing body of work that distinguishes between commitment to 'the organization' versus commitment to 'the strategy' (Fedor et al, 2006; Ford et al, 2003). It reinforces how *organizational commitment* and *strategy commitment* can be considered as separate constructs for analysis when studying commitment. It makes clear that there are conceptual distinctions between commitment 'to change' versus commitment 'to the organization'. For example, T3 data shows that despite middle manager's[56] low level of strategy commitment, i.e. being no longer inclined to participate in the addictions strategy process or else actively looking for work elsewhere, they were not necessarily intent upon leaving their respective parent organizations.

Middle managers intended to remain in their organizations (Porter et al, 1974), but they did not wish to stay involved in the integrated addiction service or the joint strategy. The addictions strategy was only one of many strategies that their organizations were responsible for developing and implementing. These actors were willing to continue to work hard on behalf of their organizations (Mowday et al, 1979). Indeed, many remained committed to other aspects of their organizations broad health and social care strategy portfolios. Hospital Health managers remained committed to NHSGG's mental health strategy and Social Work managers remained committed to GCC's child protection strategy. The addictions strategy had not gained their full acceptance, but actors' commitment to their organizations remained intact.

[56] Namely, horizontally co-opted CAT, Community Health, and Hospital Health managers

9.1.2 Strategy-as-practice

In addressing the strategy-as-practice research agenda, this study examines the strategy L-C relationship at a micro-level of analysis (Johnson et al, 2003), and identifies a range of thinking, discursive, and behavioural practices which middle managers draw upon when strategizing under umbrella conditions (Mintzberg & Waters, 1985; Whittington, 2001).

It supports others' research which draws attention to the significant role that middle managers play in the strategic change process (Floyd & Wooldridge, 2000; Mantere & Vaara, 2008; Rouleau, 2005). Understanding middle manager's evaluations are important in umbrella contexts because it demonstrates that there is much more going on outwith top management teams, in sensemaking terms, when firms adopt this type of approach to managing change (Balogun & Johnson, 2005). It recognizes those actors who can be considered as 'strategists' in umbrella contexts as being those middle managers who are on the periphery out-with top management teams who are co-opted into the strategy development process by top management (Jarzabkowski et al, 2007).

In doing so, the study offers a contribution to the portraiture of the practitioner, as it presents strategists as reflective actors, some of whom are acutely aware of their scope for exercising managerial agency. It demonstrates how middle manager strategists cannot be considered purely as passive actors (Giddens, 1984) by offering evidence of human action and describing how middle managers use calculated activity and calculated inactivity when strategizing, that they are mindful of normative institutional constraints when acting, and that they intentionally use vertical deferment for political purposes and acts of protest.

Methodologically, it shows how qualitative data can help illuminate the basis of actor's commitment (O'Reilly & Chatman, 1986), as well as the reasoning and legitimacy criteria which middle managers deploy when strategizing (Suchman, 1995). By gathering qualitative data in real-time, it addresses Johnson et al's (2003: p10) call for researchers to carry out in-depth studies that "uncover" strategic activities in their real-time rather than just retrospectively.

It highlights the value of using a narrative approach to study strategizing, as middle managers narratives help shed light on the reasoning underpinning their acceptance, approval, and contribution towards strategic goals (Barry & Elmes, 1997; Regner, 2003), and what they *do* in practice when developing the finer details of an umbrella strategy en route. For example, it

helped Joe to disclose his act of *"holding back"* from what top management expected him to be doing in his vertically-co-opted role, as well as allow GPs to describe the justifications underpinning their counter-acting control tactics. This approach also helped illustrate that middle managers draw upon multiple criteria to justify and legitimize their doings i.e. on pragmatic, moral, and cognitive grounds (Suchman, 1995), and that these often conflicting legitimacy variants play a critical role in underpinning their reasoning and strategizing activities.

A narrative approach helped show that in practice, strategy as a process involves considerable to-ing and fro-ing, with middle and top managers going back and forward when formulating, and re-formulating the content of strategy goals en route. It demonstrates that the strategy process is not a linear process when middle manager's narrative accounts of change are examined over time (Balogun et al, 2007; Langley, 1999), and that 'real-life' strategies appear to involve both deliberate and emergent elements (Johnson et al, 2008; Mintzberg & Waters, 1985). For example, by T2, top management had de-prioritized fully implementing the exit strategy in favour of more immediate financial concerns about increasing enhanced services payments to GPs. Consequently, capacity management issues became a secondary issue in contrast to the financial prerogatives of NHSGG.

This thesis also offers a contribution to furthering the research agenda for strategy-as-practice framework in terms of developing the 'V' links and relationships that Johnson et al (2007: p17) have proposed in their organizing framework (see Illustration 9.1.2). In addition to the importance of *institutional* and *organizational* contexts which Johnson et al (2007) currently emphasize, this thesis illustrates that the *strategic context* in which actors are situated is critical to understanding their practices. Namely, that the *type* of approach a firm adopts to manage change can influence middle managers' thinking, discursive, and behavioural practices.

Third-order data shows that 'the doings' or practices of middle managers were directly attributed to the strategic context in which they were situated. 'What these strategists did, and why' (Balogun et al, 2007: p204) (i.e. how they thought, what they said, what they did and why) was influenced by the type of approach that the organizations in this case study deployed to manage strategic change. The strategic context of this case study proved critical to understanding middle managers' reasoning and actitivies when conferring legitimacy and committing to change.

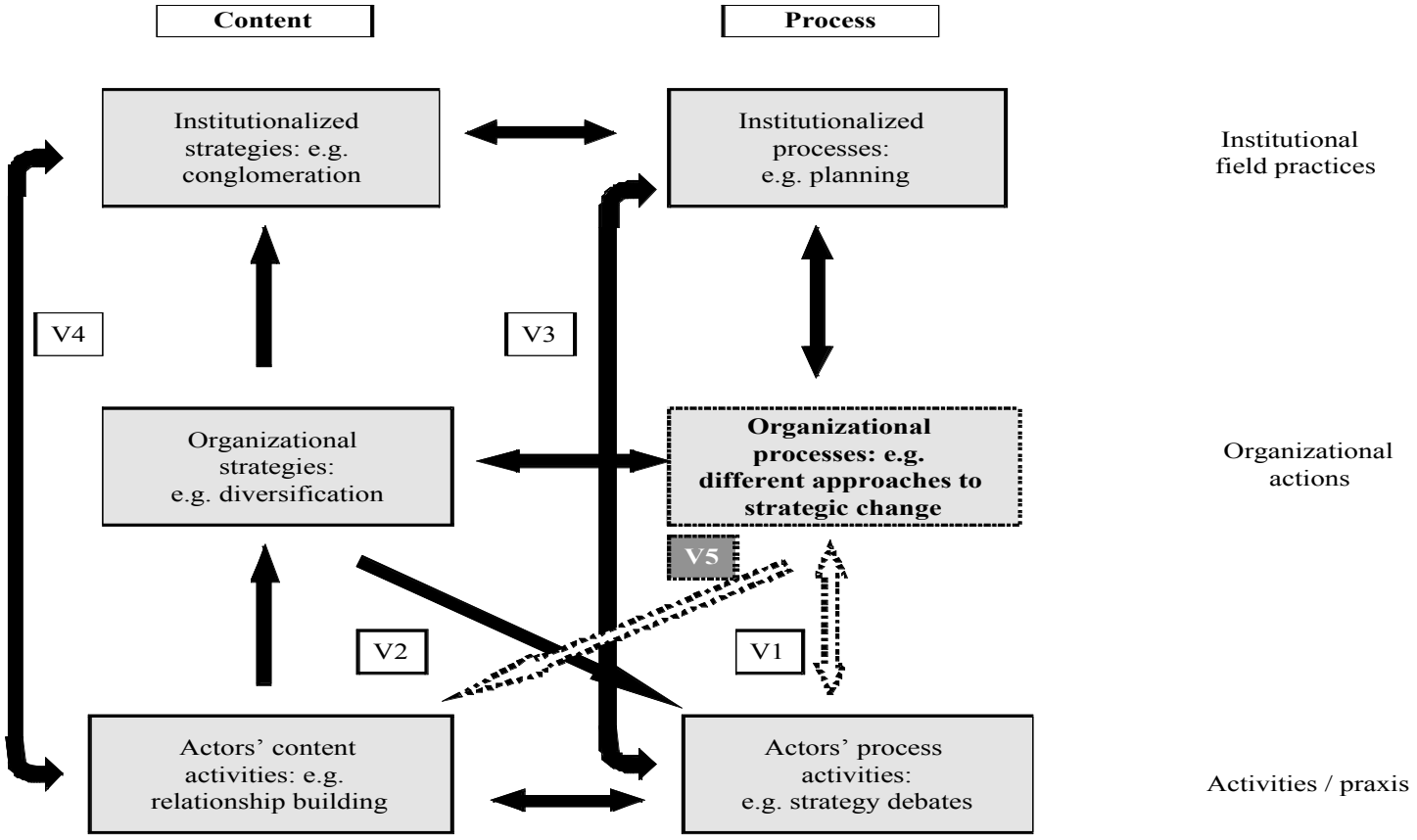
Managerial agency is dependent on both general and situtational constraints (Whittington, 1988), and umbrella strategy approaches, or dialogization-type processes such as umbrella strategies, consist of both constraining and enabling conditions (Mantere & Vaara, 2008). Therefore, the *type* of approach that organizations adopt requires particular attention if strategy-as-practice researchers are to better understand and analyze actors activities and practices. It is critical to acknowledge the strategic context in which middle managers' practices develop and occur.

Johnson et al (2007) proposes four linkages ('V1-V4') that represent the relationships between actors' micro-level activities with macro-level organizational and institutional practices (p17). This thesis proposes a 'V5' linkage between organizational processes and actors' content and process activities. It is argued that different *types* of strategic approaches may provide more or less enabling conditions to middle manager strategists than umbrella strategies do. Namely, planned or ideological approaches may prove far less enabling than unconnected or emergent approaches (Mintzberg & Waters, 1985), and that middle managers' discretionary practices may be more constrained in some strategic contexts than in others (DiMaggio & Powell, 1983; Scott, 2001).

For example, umbrella conditions influenced the scope that actors perceived they had to 'act otherwise' (Giddens, 1984) e.g. when they perceive themselves to have a *"blank canvas."* In many ways, the umbrella approach provided the enabling conditions for middle managers to exercise their managerial agency in ways that proved both helpful and unhelpful to fulfilling the espoused strategic aims of top management (Mantere, 2007).

Although the broad principles of the strategy may have been stipulated by top management at the outset (Quinn, 1980), the activities that are necessary for their execution are not always developed by middle managers as umbrella conditions provide scope for 'managerial opportunism' and actions that are motivated by self-interest (Angwin, 2007). Some emergent activities can subsequently become difficult for top management to control and monitor. Discretionary middle manager practices, which actors are afforded under umbrella conditions, can prove to be consequential for firm outcomes (Jarzabkowski et al, 2007.

Illustration 9.1.2



9.1.3 Limitations of the research

Although the L-C relationship has been shown to produce reciprocal, non-reciprocal and dual relationships with umbrella strategies, this might not be the case in other strategic contexts which Mintzberg & Waters (1985) include in their typology. Therefore, what has been found in this study may not necessarily be applicable in other types of strategic context. It is also possible that different legitimacy frameworks (e.g. Scott, 2001) and models of commitment (e.g. Meyer & Allen, 1991; Meyer & Herscovitch, 2001) may produce different findings when examining the L-C relationship compared to Suchman's (1995) and O'Reilly & Chatman's (1986) frameworks.

Methodologically, this study draws extensively on middle managers' narratives (Barry & Elmes, 1997; Langley, 1999). However, were strategy legitimacy and commitment variables to be measured quantitatively, different findings may emerge. The L-C relationship findings may also differ, were top management or lower level employees used to form a similar studies' sample group. Although this study included middle managers only, it would be useful to compare and contrast the L-C relationships across other managerial and non-managerial groups at different levels of the firm to further support the findings of this study.

9.2 Implications for managerial practice

The research findings have implications for managerial practice on three levels: (i) the benefits and risks of adopting umbrella approaches to managing strategic change; (ii) the reasons for, appropriateness, timing, and effects of top management intervention en route; and (iii) the feasibility of simultaneously fostering legitimacy to attain commitment (or vice versa) to aid successful strategic change.

First, this research shows how two organizations adopted an approach to strategic change that involved both deliberate and emergent elements. It adds to the small but emerging body of research which reflects the central characteristics of Mintzberg & Water's (1985) umbrella strategy typology (Brodwin & Bourgeois, 1984; Lovas & Goshal, 2000; Mantere & Vaara, 2008; Quinn, 1980; Vila & Canales, 2008). In contrast to Quinn (1980) and Vila & Canales' (2008) success stories of deliberately-emergent strategizing, this study provides a narrative account that describes change failure more than it does change success.

Nevertheless, umbrella strategies may be appealing to firms because of the way they can accommodate and combine planning and participation (Mantere, 2007). Although umbrella

strategies are vulnerable to the same type of external factors that formally-planned strategies are (Mintzberg, 1994; Raimond & Eden, 1990; Sull, 2004), they do offer top management the flexibility to alter their plans quickly as shown with the radical changes that were made to the CAT model during the first six months of the process. This iterative process appears to aid problems that top management do not anticipate, and where the details of the strategy needed to be revised or re-planned altogether.

There are many benefits to participation and inclusion as the HRM literature has shown (Sagie & Kowlowsy, 2000), and these remain applicable to those firms who choose to adopt umbrella approaches when managing strategic change. Top management can also use consultation exercises in parallel with co-opting middle managers into the strategy processes as a means of meeting the social expectations of their environment (Suchman, 1995).

Conversely, there are clearly some potential pitfalls for top management teams who formally co-opt middle managers into the umbrella development process. These risks have been underplayed to some extent by umbrella researchers (e.g. Quinn, 1980; Vila & Canales, 2008). Encouraging participation and involvement en route is perhaps a well-meaning legitimacy-seeking practice for the change itself (Fiss & Zajac, 2006; Tyler et al, 1997), but it carries with it the risk of compromising the planned intended strategy by increasing the scope for middle manager agents to subvert the broad principles of the deliberate element of the strategy en route (Campbell-Hunt, 2007; Guth & McMillan, 1986; Mintzberg, 1994; Whittington, 1992). For example, top management and CAT managers did not expect Specialist Health managers would *"exploit the gaps"* in such an over-enthusiastic and *"aggressive"* manner once they were co-opted into the process. This type of emergent activity subsequently proved unhelpful to CATs.

The co-optation and involvement of Specialist Health managers created the opposite desired effect of what top management had intended i.e. *"that agencies must not pass the buck."* This suggests that it is difficult to predict how middle managers will respond to the generalities of broad strategy goals, as their knowledge and interpretations can subsequently shape emergent activity in ways that prove counter-productive to implementation (Balogun & Johnson, 2005; McKinley & Sherer, 2000).

The lesson here appears to be that top management can co-opt middle managers into the umbrella process as key strategists, but these managers may not necessarily contribute in ways which top management had anticipated. Allowing middle managers the opportunity to

make a constructive contribution to strategy goals through their knowledge and expertise (Quinn, 1980; Nutt, 1989) may paradoxically create the opposite desired effect of co-optation (Swanberg & O'Connor, 1995).

Second, the research findings raise questions about the reasons for, appropriateness, timing, and effects of top management intervention en route under umbrella conditions. In this case study, top management were required to intervene en route for two main reasons: one, to gain or regain control of the strategy process; and two, to problem-solve in response to middle manager requests that they provide greater clarity and direction, and that they offer more explicit guidance by issuing edicts and formalizing protocols. The latter occurred because top management were largely absent early on in the umbrella process unless they were called upon by middle managers for direction (Balogun & Johnson, 2005; Darragh & Campbell, 2001).

Nutt (2000) has previously drawn attention to the problem of top management failing to address beforehand various tensions or under-developed aspects of strategy that subsequently resurface en route. Indeed, in this case study, the umbrella process was punctuated by top management interventions that were initiated by middle managers themselves. Ultimately, top management input, and their presence, was demanded from middle managers. However, it is *how* top management react under umbrella conditions which is critical because their decision to intervene, or not, has implications for the way in which middle managers legitimize, and commit to, strategic change.

The absence of top management intervention en route was shown to negatively contribute to middle manager's low (*procedural*) strategy legitimacy as well as their low *(behavioural and attitudinal)* strategy commitment. Yet, when top management did intervene, this was looked upon favourably, as opposed to being perceived as intrusive, autocratic, or interfering. For example, their intervention to directly address the problems of CATs and the HAT at T2 were greeted positively. It created greater optimism and hope among Specialist Service managers that the development and execution of Goal 1 could be achieved despite initial problems. Hospital Health managers responded in the same way at T2 when there was greater dialogue with top management. In contrast, top managements' inaction concerning the management of CAT clinics created the opposite effect by T3, whereby horizontally co-opted CAT middle managers felt abandoned and neglected, as they were not receiving enough support to find ways of overcoming the problems that had emerged.

This issue raises a question of for how long top management should stand back from the emergent process in order to allow their middle managers to continue to develop the finer details of strategic goals on their own. This case example suggests that top management need not be over-cautious about intervening en route, even if they have already publicly deferred developing the finer details to middle managers through co-optation. Indeed, it seems entirely appropriate that they choose to intervene when middle managers are struggling, in crisis, and actively seeking direction.

Nevertheless, top management teams may be reluctant to adopt a prescriptive approach by intervening in this way for fear that new edicts or directives creates resentment or further disorientation among middle managers. But the reaction of many middle managers in this study showed that they actually favoured an interventionist prescriptive approach by top management to provide clarity around addressing new problems.

Top management intervention en route may not be such a simple step for another reason. Intervention en route potentially has consequences for top-level managerial identity (Ginzel et al, 2004; Gioia et al, 2004) as it could positively or adversely change the perceptions about their competence as strategists in the eyes of those middle managers whom they manage.

For example, intervention may be perceived as a sign of top management needing to reassert their traditional authority as the strategy planning experts or 'fixers' (Ansoff, 1965; Barnard, 1938), and to put right the issues that middle managers have been unable to solve on their own. But conversely, intervention could be seen as a public admission that the deliberate elements of the umbrella strategy were inadequate or flawed in the first place, to the extent that they provide middle managers with few starting points from which to orientate themselves in order to begin to engage in successful emergent strategizing. Such an acknowledgement invites further scrutiny of top management, and in the process, potentially exposes more strategic gaps and criticism.

On a personal level, this may prove too emotionally troublesome for some top managers if it forces them to re-evaluate their strategic competence and managerial credibility (Kets de Vries, 2001), especially under the glare of publicity and middle manager criticism. However, the consequences of top managers resisting intervention en route is that middle managers continue to engage in unsuccessful strategizing that eventually becomes so all-consuming and emotionally preoccupying for them (Huy, 2001; Sims, 2003), that their effectiveness or their value as 'strategic assets' is compromised (Floyd & Wooldridge, 1997). Furthermore, as this

case study has shown, middle manager strategists eventually opt-out of the umbrella strategy process altogether when there is a lack of top management intervention when problems emerge, or where engagement is inconsistent and periodic (i.e. Hospital Health). The findings of this study suggest that, if top management do intervene, they must interact consistently and be responsive in a less random and selective fashion (Hrebiniak, 2006).

How much top management's physical presence is required once they have deferred strategic responsibility to the middle of the organization is another issue. Clearly, umbrella strategies do require some form of top management engagement with middle managers about the progression of the finer details en route. A top-to-middle or middle-to-top dialogue needs to be established to help umbrella strategizing become a more effective collaborative process. Indeed, based on the narratives of Community Health managers at T1, it seems entirely appropriate that some form of formalized dialogue or 'feedback loop' (Balogun & Johnson, 1998: p77) is required to link those middle manager sub-groups who occupy different departments and strategize on the periphery of the organization (Johnson & Huff, 1997). Without such a dialogue, the benefits of co-optation decrease and are significantly reduced.

It could be argued that without some degree of monitoring or performance review process in place for middle managers who are engaged in strategizing en route, there is a risk that discretionary judgements and divergent behavioural practices, knowingly or unknowingly, come into conflict with the broad principles of the deliberately-planned elements of an umbrella strategy. Over time, these can go undetected, and tend only to surface when a crisis situation occurs, or when the impact of a new strategy is audited or evaluated and subsequently highlights how the broad principles have been subverted.

In management practice terms, this thesis does not call for draconian control mechanisms on the activities of middle managers to be enforced. But instead, it highlights that umbrella strategies do require some form of top management engagement with middle managers about the progression of the finer details en route if they are to better understand and control the direction of the umbrella strategy.

Third, the findings of this research raises questions about the feasibility of simultaneously fostering strategy legitimacy to attain strategy commitment (or vice versa) in umbrella contexts when multiple legitimacy and commitment variants are prone to such fluctuation en route. At present, it would appear that no clear "actionable guidance" (Johnson et al, 2003:

p15) can, or should, be offered to practitioners based on the coupling of legitimacy and commitment concepts that the normative view holds.

Many researchers have previously offered useful guidance with regards to managing strategy legitimacy (Elsbach & Sutton, 1992; Jarzabkowski, 2005; Pfeffer & Salancik, 2003; Ruef & Scott, 1998; Suchman, 1995; Vaara et al, 2006), or else the winning, development, and attainment of actors' commitment (Beer et al, 1990; Cartwright & Holmes, 2006; Fiol, 2001; Lee & Miller, 1999; Wright et al, 2001). This advice is not challenged or disputed in this thesis.

However, the data from this study suggests that it is inherently difficult, if not unachievable, to simultaneously manage legitimacy and commitment *together* due to the dynamic and temporal nature of middle managers' strategy legitimacy and strategy commitment evaluations under umbrella conditions. Managing legitimacy and developing commitment are both recognized as challenging in their own right (Mowday, 1999; Suchman, 1995), but simultaneously coupling them with the aim of creating interdependency, and on the premise of reciprocity, is an entirely different proposition altogether in terms of the manageability of such a process.

The data findings offer evidence that influencing actors' interpretations towards one direction or another through the use of edicts and participation (Nutt, 1989, 1998) is extremely complex (Balogun & Johnson, 1998; Bartunek, 1984; Gioia et al, 1994). This is perhaps even more difficult when top management change the content or process of strategy goals (e.g. introducing the new CAT model by T2). As top management change strategy details in an emergent way en route, new ways of doing things are also going to be subject to legitimacy evaluations. This requires actors to re-adjust and re-orientate from what was initially communicated to them early on in the strategy process, and to make sense of alternative and sometimes radically different propositions.

The feasibility of managing middle managers' legitimacy evaluations and levels of commitment is also more difficult when middle managers believe that they have been given *"the green light"* (cf. John's narrative), autonomy, and discretion to develop the finer details of the strategy under umbrella conditions. Furthermore, the notion of unilaterally fostering legitimacy to attain commitment also needs to be achieved across disparate groups who interpret strategic change in different ways (Balogun & Johnson, 2004; Gioia et al, 1994). As pointed out earlier, middle managers cannot be considered a homogenous group of strategic

actors (Thomas & Linstead, 2002). While one middle manager group legitimizes strategy goals, another delegitimizes them. While one group is committed, another is not. This makes top management's task even tougher, and could require separate legitimacy-commitment building strategies for each middle manager group.

Quinn (1980) has highlighted that the problem for top management in bringing together and effectively co-ordinating what different sub-systems do, in order that the integration of subsystems "form a cohesive whole" (p57). This is arguably difficult in pluralist settings (Jarzabkowski & Fenton, 2006; Van de Ven, 2004), when strategists bring with them institutional normative influences that shape their activities which conflicts with the espoused change targets of top management (Kelman, 2001), and where their loyalty and adherence to normative guidelines or directives override those required by top management to achieve such cohesiveness.

All of this might become a time-intensive exercise for top management. As this study shows, when they are not prepared to invest that time – whether they are attending to other top-level priorities or not – then it has a negative impact on middle managers' legitimacy and commitment evaluations. Importantly, it is these evaluations that have been shown to play a significant role in shaping middle managers' practices which become consequential for firm outcomes (Balogun et al, 2007).

9.3 Implications for future research

The findings of this study have shown that strategists' legitimacy and commitment evaluations are temporal and shift over time (Beck & Wilson, 2001; Pfeffer & Salancik, 2003). Therefore, it is vital that future studies which examine the L-C relationship do so using longitudinal methods, regardless of what type of approach is studied.

This thesis has highlighted the importance of *strategic context* in understanding what shapes strategists' activities, and proposes that strategy-as-practice researchers consider the strategic context that influences strategic activity in addition to *institutional* and *organizational contexts*. Mintzberg & Water's (1985) typologies (see Table 2.3) suggest that some strategic contexts are more bounded or less restrictive than others for strategists to operate within. Future practice research should consider examining what strategists do in other strategic contexts that Mintzberg & Water's (1985) have identified e.g. consensus, imposed, or

ideological strategies, or perhaps using Mantere & Vaara's (2008) strategy discourse framework which similarly outlines different approaches to strategizing.

There remains some dispute about the prevalence of deliberately-emergent approaches in contemporary strategizing (Johnson et al, 2008; Mintzberg & Waters, 2002). Determining the prevalence rates of umbrella strategies using quantitative measures and large sample sizes on the scale of previous studies by Nutt (1998, 1999) would be particularly useful in this respect. If the prevalence of deliberately-emergent strategizing is as high as managers anecdotally report (Johnson et al, 2008), and as Mintzberg & Water's claim (2002), then it has important implications for the field of strategy.

If prevalence is not high, it raises questions as to why firms do not deploy umbrella approaches more often. Conversely, if it is higher, the strategy research community require addressing the issue as to why more research has not been conducted in this area, and why it continues to rely on only several accounts of umbrella strategizing (Brodwin & Bourgeois, 1984; Lovas & Goshal, 2000; Mantere & Vaara, 2008; Quinn, 1980; Vila & Canales, 2008).

A better understanding of umbrella strategy prevalence rates may also have implications for the direction of teaching strategic management in business schools e.g. how much emphasis is placed on the deliberate-planned elements of strategy-making versus the unplanned emergent processes. In this respect, it may help 'bridge the relevance gap' (Das, 2003) were business schools to more closely reflect in their strategy syllabus the 'real-world challenges' that managers face when strategizing (Johnson et al, 2008; Mintzberg, 2004; Mintzberg et al, 2009).

Mintzberg & Water's (1985) umbrella typology is a useful conceptual mechanism for strategy-as-practice researchers in breaking down traditional paradigmatic boundaries as content versus process, and planned versus emergent (Golsorkhi et al, forthcoming). Umbrella strategies allows strategic change to be viewed in an integrated way, which strategy-as-practice researchers have advocated researchers ought to consider in approaching strategy research (Jarzabkowski et al, 2007). More strategy-as-practice umbrella studies can support the 'dismantling' of the partisan formulation-implementation divide in the field of strategy research (Jarzabkowski, 2005; Johnson et al, 2003). Practice researchers are arguably less bound to conform to content or process traditions, are perhaps best placed to undertake further research in this area.

Traditional approaches to study legitimacy remain focused on external sources of legitimacy (Deephouse, 1996; DiMaggio & Powell, 1983; Meyer & Rowan, 1977; Pfeffer & Salancik, 1978), as opposed to internal sources of legitimacy (Kelman, 2000; Kumar & Das, 2007). However, this study has shown the critical role of internal sources of legitimacy and their influence on managerial practices. The micro-level focus of the strategy-as-practice research agenda suggests that exploring the internal sources of legitimacy is a compatible and natural analytical path for practice researchers to follow (Johnson et al, 2003).

However, practice researchers should remain cautious of the discursive effects of deploying legitimacy *and* commitment in highly generic terms, and they need to acknowledge the conceptual fragmentation and semantic duplication issues that change commitment researchers have recently addressed from the field of applied psychology (Beck & Wilson, 2001; Mowday, 1999; Reichers, 1985).

Questions remain over whether management researchers ought to continue analyzing organizational commitment versus strategy commitment. Mowday (1998) has noted that some commitment researchers have suggested that commitment to 'the organization' is no longer significant to future commitment research. Baruch (1998) argues that the nature of the employment relationship has fundamentally changed in the past twenty-five years in ways that make employee commitment to organizations less relevant (p138).

Similarly, Foote et al's (2005) rationale for studying 'policy commitment' was attributed to organizational commitment being "an abstract entity" (p204). They argued that employees are finding difficulty in developing any depth of commitment to their organizations due to the pace of change in the environment where loyalty between employees and their organizations "dissolves," and "keeping track of who the organization is may present a daunting task to many employees, particularly at lower levels of the organization" (p204).

In a similar vein, this thesis argues that commitment to 'the strategy' has more managerial relevance in contemporary organizations than the concept of organizational commitment. For example, many organizations operate within partnerships or joint organizational structures (Huxham & Vangen, 2005), especially in the UK public sector (Ferlie et al, 2003; Hartley et al, 2002). Such approaches ultimately challenge the notion of commitment to a single organization. Furthermore, actors' commitment to strategy goals is arguably more critical in the short-term within competitive and turbulent environments (Eisenhardt & Brown, 1998; Fiol, 2001), and in modern work contexts (Cartwright & Holmes, 2006). Although change

commitment researchers have attempted to shift the foci of commitment from 'commitment to the organization' towards 'commitment to change,' there remains scope to further bring the concept of *strategy commitment* into strategic change discourse.

Future research should consider in more depth how middle managers deal with the resultant role conflict that can emerge as a consequence of being vertically co-opted into the umbrella strategy process. More needs to be understood about the challenges they face, as it is clear that these managers face certain types of pressures and demands in umbrella strategic contexts that other middle managers do not. For example, what are the longer-term personal, emotional, and career consequences for vertically co-opted middle managers who develop 'top management rhetoric' and whose identity is reconstructed by their horizontally co-opted middle manager colleagues?

This case study shows how middle managers are often expected to engage in strategizing across organizational boundaries. There appears to be scope to understand more about middle manager practices when deliberately-emergent approaches are used and more than one organization is involved in developing and implementing strategic change (Balogun et al, 2005). Margaret's experience was arguably more difficult than Joe's as she was based in the office of 'the other' parent organization. Her experience was also more negative. Therefore, using deliberately-emergent approaches when there is a perceived dominant organization (Huxham & Vangen, 2005) is worthy of examination in terms of *which* middle managers from one or the other parent organization shape the development and implementation process.

Finally, in a number of cases, the research findings suggest that pragmatic legitimacy overrides moral legitimacy in shaping what middle managers do during strategic change. Although this thesis did not set out to address this particular issue, the findings appear to offer an interesting route for future agency-related research in terms of exploring further the role of middle manager role as constructive or destructive.

9.4 Reflections on the doctoral process

Although there are many theoretical and practical issues about the doctoral research process which I have reflected upon, there are four points in particular that are noteworthy mainly in terms of what I might have done differently, and how my experience affects how I conduct future research.

First, Balogun, Johnson & Huff (2003) have highlighted a number of methodological challenges for strategy-as-practice researchers. One issue that resonates with my own research experience relates to the issue of co-ownership of data and agreeing equal ownership rights (p219).

The three research sponsors (i.e. NHSGG, GCC, and the Scottish Executive) were initially very keen for the interim and final evaluation reports to be honest, open, and as detailed as possible. However, as the evaluation began to produce much politically-sensitive (i.e. GP contract related-issues) and emotionally-charged data, I was often pressurized to omit sensitive parts of the data by NHSGG's research manager.

As T1, T2, and T3 data was formally fed back to top management ('the research collaborators'), they subsequently decided to restrict the use and dissemination of the findings, even though the original purpose of evaluation was for organizational learning. My interpretation of the reason for their decision was because middle managers' narratives often portrayed top management in a bad light.

On completing the evaluation, the Scottish Executive's Effective Interventions Unit did not wish to publish the evaluation report in its entirety because they considered its content "too inflammatory." Meaning, they could not portray middle managers in Glasgow as openly questioning the merits of the Scottish government's integrated strategy for addiction services. The outcome of subsequent negotiations between myself, NHSGG, GCC, and the Scottish Executive, was that a short, summarized, and highly (politically) edited version of the evaluation report be disseminated and published on the Scottish government's website. Under these circumstances, I conceded to omissions, adjustments, and "trade-offs" (Johnson et al, 2007: p65) for pragmatic reasons. Namely, that the integrity, credibility, analysis, and accuracy of the data should be upheld for doctoral research purposes if not for the government and organizations' reports.

Although there is a need for researchers to maintain control over data, it is clear that change-related research that is sponsored at top-management level becomes as much a political tool as it does a learning tool. For example, a key phrase used by some middle managers in the evaluation report *("integration was the right way to go")*, was later used by an executive from NHSGG who held up a copy of my evaluation report at a public board meeting to ask others to mandate the move towards integrated structures for other types of community care services, on the basis that CATs were considered to be a major success by the report's author.

The caveat to this phrase *("it was not the right way to go for the staff")* did not follow such discourses around the evaluation reports wider findings. While learning from more recent experience that the terms and conditions of research must be explicitly and formally agreed with sponsors at the outset (Keenan, Beech & MacIntosh forthcoming), I've also come to accept that research sponsors can selectively highlight, and omit, research findings to accommodate their own prevailing political agendas.

Second, longitudinal approaches clearly offer important methodological benefits for strategy-as-practice research (Johnson et al, 2007). However, throughout the data collection process, I found that managers became more open during T2 and T3 interviews, and began disclosing information which was often highly confidential and very personal. My interpretation of why this appeared to be happening was due to greater participant-researcher familiarity, that enabled a degree of trust to develop before, during, and after interviews.

In parallel to this, the quality and richness of the data that was emerging from T2 and T3 interviews allowed me to 'uncover' more micro-level, intimate details of umbrella strategizing. This suggests that conducting longitudinal practice research is as much a social process as an academic process. Practice researchers should not underestimate the way in which it enables strategists to feel comfortable about revealing what they do. In comparison to non-longitudinal qualitative research that I have since undertaken, this thesis' case study reinforced to me the value of conducting longitudinal research to facilitate participant openness, as well as allowing actors more than one opportunity to reflect upon, and construct more in-depth narrative accounts of, their strategizing experience (Rouleau, 2004).

Third, although a detailed semi-structured interview schedule was designed to guide the interview process, I did not hold the interview schedule in front of me, nor was it visible to participants. Each of the interview questions were followed, more or less, systematically from start to end. The only other 'tools' used were a tape recorder and a coffee mug. These enabled

interviews to be more conversational and informal, instead of making them feel like a formal Q&A session.

From my professional work as nurse therapist working with those suffering from paranoid delusions, I had learned to visually memorize the schemata of my therapy session questions, as some individuals were often mistrusting and uncomfortable about my writing down notes after they voiced something of significance. Unexpectedly, I found that this technique worked particularly well in engaging with managers during interviews. So much so, that it is a technique that I will continue to use because of its benefits in collaboratively engaging with practitioners in the research interview process.

Fourth, practice researchers have been encouraged to reveal the micro-level intimate details of the strategy process (Johnson et al, 2003). Using in-depth qualitative interviews is central to facilitating this process, and to 'bring human actors to the front stage' (Balogun et al, 2007). However, this process can lead to strategists revealing aspects of change which are emotionally-troubling for them on a professional and personal level.

Obviously, the central purpose of interviews is to collect qualitative data for research purposes. Yet, on several occasions at the end ofT3 interviews, it was difficult to switch off the tape recorder, thank participants for their co-operation, and then leave the room while managers were wiping the tears from their eyes and were still visibly angered by top managements' failure to recognize their plight. Admittedly, I was quite taken aback at the depth of emotion and the level of anger and hopelessness that CAT managers expressed at T3. On these occasions, I found myself providing some brief post-interview counselling using simple techniques and offering words of encouragement and support, only for the reason that I have been trained to do so.

These post-interview experiences led me to consider the role of the research interview process in creating such heightened emotions that can be very unsettling for managers. On one level, interviews appeared to be beneficial to individual manager's sensemaking, as well as allowing them the opportunity to ventilate their feelings about the change process. But for others, the interview process crystallized many different emotions to the degree that eyes welled-up, tears were shed, expletives were used aplenty, and requests were made to switch the tape recorder off until individuals regained their composure.

Initiating a process that induces managers' *"realization that they hate their jobs,"* whereby researchers make managers *"feel depressed"* post-interview raises an important ethical question for practice researchers who stumble upon a range of unpleasant emotions which managers associate with the change process. Should one 'run for the door' or stay and attempt to alleviate managers' distress, which the interview process may have played a catalytic role by helping surface such upsetting emotions? My own instinct was to opt for the latter. However, it has led me to conclude that if practice researchers prise open the 'can of worms', which is arguably the basis of rich in-depth micro-level data, they must also be prepared for the potential emotional consequences (for participants) of doing so.

APPENDICES

Appendix 1

MACRO -LEVEL INFLUENCES FOR INTEGRATED ADDICTION SERVICES

Five key national drivers are summarized to provide the wider institutional context which influenced the introduction of integrated addiction services and CATs. All five are listed in chronological order.

Tackling Drugs in Scotland: Action in Partnership, Scottish Advisory Committee on Drug Misuse (1999)

Scotland's drugs strategy was set against the background of the UK White Paper *Tackling Drugs to Build a Better Britain* (1998), which built on the Ministerial Drugs Task Force Report *Drugs in Scotland: Meeting the Challenge* (Lord Fraser, 1994). The Scottish strategy outlined four key principles: inclusion, partnership, understanding and accountability. It emphasized partnership driving forward delivery of local strategies by supporting the pivotal nature of the role of local DATs, who would be required to provide 3-5 year corporate action plans reflecting local circumstances and views.

The national strategy also stated that coordinated and collective work on drug misuse would achieve far more than independent and fragmented activity, and encouraged involvement at every level of implementation to include the Scottish Advisory Committee on Drug Misuse (SACDM), NHS and Local Authority management levels, Scottish Police Forces, HM Customs & Excise, voluntary agencies and community drug workers, Scottish Drugs Forum, Scotland Against Drugs, Health Education Board for Scotland (HEBS), Scottish Drug Misuse Information Strategy Team, Scottish Prison Service and the courts.

Joint Futures Strategy (2000)

In December 1999, Scottish Ministers for Health established the Joint Future Group for Community Care. It followed a post-devolution summit of NHS Chairs, Local Authority leaders and Chief Executives, which produced consensus that joint working had not developed as anticipated under "Modernising Community Care – An Action Plan" (1998). The Joint Future's Group report, "Community Care: A Joint Future" (December, 2000) became known to as the "Joint Future Agenda", and made nineteen key recommendations that initially focused on services for elderly people, however, would also apply to other

community care services provided by health and social care services e.g. Addictions, Mental Health, Physical Disability, Learning Disability, and Child Services.

The Joint Futures Strategy recommended the introduction of a Single Shared Assessment, development of the Care Management (coordinated) approach to care, and the formation of Local Partnership Agreements between health boards and local authorities. These agreements were to outline joint development priorities and targets for 3-year periods, as well as the development of joint service management and joint resourcing to support the joint priorities. Performance management frameworks, straddling a number of partnership agencies were proposed, as well as clear empowerment and reporting lines to parent agencies. The strategy also highlighted the challenges that the Joint Future Strategy presented for human resource management**.**

"We acknowledge that people, not just structures, create and support change…. We need to help staff across agencies overcome barriers to change... Added importance attaches to breaking down traditional cultures, rigid employment practice and differing terms and conditions in both health and social care." (Joint Future Strategy, December, 2000)

Plan for Action on Alcohol Problems, Scottish Advisory Committee on Alcohol Misuse (SACAM, 2002)

The alcohol plan identified the need to improve services for people with alcohol problems and those close to them. It highlighted the general perception that service coverage in Scotland was patchy and fragmented with disparity in support and treatment across the country. The plan stated that services should be properly coordinated where they are provided by separate agencies, and link up with those that tackle drugs, mental health, homelessness, maternity, children's services, community care and the criminal justice system. It also recommended that services should be designed with input from service users, carers and communities.

Initially, the plan did not prescribe whether drugs and alcohol issues should be addressed by the same body, however, where Alcohol Misuse Coordinating Committee's (AMCC's) combined with DATs, it stated alcohol issues should be given higher priority on the agenda than they currently were. In addition, it recognised that training was required for staff across a range of disciplines and agencies that addressed alcohol problems, and this training required to be updated and revised by STRADA (Scottish Training on Alcohol and Drug Abuse).

Community Care & Health Act (2002)

This legislation allowed NHS Boards and Local Authorities in Scotland to 'pool budgets' for the first time. The Community Care & Health Act (2002), effectively enabled expansion of joint resourcing and management of services between Health Boards and Local Authorities.

NHS White Paper: Partnership for Care (2003)

Partnership for Care proposed the introduction of Community Health Partnerships (CHP's) in Scotland, and NHS Boards were directed to dissolve NHS Trusts by 1 April 2005. CHP's were envisaged to allow authority to be devolved as far as possible and enable health professionals to improve patient care, be more accountable to local communities, be better matched with social work services and better able to represent local interests within the NHS Boards.

"Patients want simple streamlined services. So we emphasize the integration of services within NHS Scotland…between NHS Scotland and the social work services of Local Authorities." (Partnership for Care, 2003)

Appendix 2

MESO -LEVEL INFLUENCES FOR INTEGRATED ADDICTION SERVICES

Glasgow City Council Addiction Services Review (2001)

The review brought GCC Addiction teams across Glasgow into the core social work services structure during 2001, and new service specifications for addictions, new managerial structures and new lines of accountability were introduced. The approach was adopted to increase joint working between local Children & Families teams and Criminal Justice teams based within the GCC Social Work Services Area Teams. Specialist addiction support by social care workers was in operation in nine area teams across the city, and provided support to primary care and generic social work services. However, addictions support was not matched with any locally based specialist health input.

Joint Review of the Methadone Programme (2001)

Greater Glasgow NHS Board and GCC Addiction Services jointly carried out a review of the methadone programme in Glasgow in order to establish the level of need for clients attending methadone clinics in terms of social support, and to determine the best use of resources in managing methadone for both organisations. The outcome of the review led to increased social care support for GP Shared Care Scheme methadone clinics and recognition for the need of greater levels of joint working between health and social care staff.

Joint Purchased Services Review (2002)

A review of purchased services was carried out by Greater Glasgow NHS Board and Glasgow City Council to examine referral patterns of residential services purchased by both organisations. The review found that residential services were generally used for chaotic clients, and the use of community and residential services varied among the nine social work addiction service locality boundaries. The review also found that inconsistency characterised assessment procedures, and decision-making processes in determining which service a client would be referred to was often influenced by many different variables, and that communication between rehabilitation and social work addiction services required further improvement.

Other local strategic drivers were those that were guided by the national strategies for health

and social care services, as outlined above, which took into account local organisation of services and community group needs. These included:

- Greater Glasgow DAT Strategy (1999-2003)
- Greater Glasgow AAT Strategy (2000-2003)
- NHS Greater Glasgow Modernising Mental Health Strategy (2000)
- Glasgow Joint Community Care Plan (2001-2004)
- NHS Greater Glasgow Local Health Plan (2002-2005)
- Glasgow City Council Criminal Justice Plan (2002-2005)
- Glasgow City Children's Services Plan (2002-2004)
- Glasgow City Homelessness Partnership Strategy (2003)

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