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Survivors and Victims: a Case Study of Organisational Restructuring in the Public Health Sector

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This paper examines a process of major organisational restructuring in an Australian hospital within a context of decentralisation of health services and relocation of clients, brought about by changes in government policy. The change process differed from the abrupt downsizing often found in the private sector in that the organisation initiated significant job losses concomitantly with the development of new facilities around the State, while attempting to deal with employee issues related to downsizing. The paper focuses on the process involved in the downsizing, from the perspective of both the "survivors" and "victims" of the change. It draws on interviews and focus groups with managers, union officials and employees, as well a survey of employees to assess the outcomes and effectiveness of the restructuring process. Using a stakeholder analysis framework, the paper examines the complex issues and perspectives raised by the downsizing process.

Introduction

Significant organisational restructuring has been undertaken in the Australian health care industry and this paper discusses the major changes that occurred in one health care facility. As Dunford, Bramble and Littler (1998: 387) note, a central element of the restructuring of public and private sector organisations is the substantial reduction of employee numbers and this occurred in the instance discussed in this paper. "Downsizing" is a generic term referring to this form of restructuring, which can permit a number of courses of action. These include: first, a direct reduction in the number of staff who carry out the organisation's existing activities through across-the-board cuts or the reduction of staff involved in a specific activity; second, the centralisation of infrastructural functions such as administration and public relations, which results in a loss of jobs; and third, the reduction in the number of levels ("delayering") in the organisation that may lead to staff reductions (Dunford et al., 1998: 387–388).

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Downsizing is most often associated with a response to falling profits and the need for cost reduction (De Witt, 1998; Robbins and Pearce, 1992). However, McKinley and Mone (1998: 199) report that downsizing is now being implemented in profitable organisations that do not face actual or impending revenue declines. This non-revenue driven restructuring and downsizing has occurred in public sector organisations in search of efficiencies and changes in modes of service delivery (Ryan, Parker and Hutchings, 1999: 122-123).

Regardless of the organisational intention behind downsizing, the process of change and the employment outcomes can have a dramatic impact on employees' working and personal lives. Appelbaum and Leblanc (1998) report symptoms of an unproductive "survivor" culture, amongst those who remain in an organisation after significant downsizing. Survivor attitudes may include disbelief, guilt and betrayal, and may result in lack of motivation, loyalty, trust and recommitment to the new organisation (Ryan and Macky, 1998: 35; Mishra and Gretchen 1998: 567-568). Further, the downsizing process can leave employees with feelings of anger and frustration. The literature has tended to classify these employees under the terms, "survivors" and "victims". The survivor/victim dichotomy remains problematic as persons who remain in organisations can have their job status radically changed while those who leave the organisation may eventually gain from the experience. However, in this research the term "survivor" is used to describe those who stay in the organisation while the term "victim" is used to define those who no longer work at the physical location of their former employment.

Isaksson and Johansson (2000: 241-243) report that studies into the effects of downsizing have tended to focus on the victims and their job status following downsizing. However, they note that in the last decade there have been a number of studies on employees who have remained in organisations following restructuring or personnel cut backs. They report that studies have found that the perceived fairness of the downsizing process, level of job security following downsizing, influence over the downsizing process and prior organisational commitment are all important in the favourable reactions of survivors to downsizing and survivor job satisfaction. This paper examines the process employed in the restructuring and downsizing of a large psychiatric facility in Australia (Facility Z). In this case, the restructuring was driven by policy changes and new approaches to the delivery of psychiatric care. The paper focuses on barriers to change brought about by the historical makeup and goals of the organisation as well as problems encountered as a result of the chosen process for change. A preliminary examination of the outcomes of the change on employees is also provided. Utilising a range of research methodologies, findings are reported from the perspectives of different stakeholders.

Background to restructuring: the historical legacy

Historically, like many other mental health institutions, Facility Z had been resistant to change. Established in the nineteenth century, it had a highly distinctive culture, built

on successive generations of staff from the surrounding area, for whom employment in the institution usually meant a "job for life". Throughout its history, Facility Z had been the focus of various governmental inquiries and occasional attempts at reform. Until the early 1990s, however, it remained a large mental health institution, accommodating a wide range of people with a diverse range of psychiatric and social problems of varying severity.

During this period, though, several factors emerged to initiate a period of rapid organisational change. These included the Commonwealth Government's "Better Cities" program (announced in the 1991-92 Budget), which proposed the reform of institutional care, the poor ratings given to the State's mental health services by the Burdekin Report (1993), and the formation of new State and National Mental Health Policies. The State Mental Health Plan, which followed these developments, articulated two main principles: firstly, regionalisation (whereby the planning of health services was to be devolved from the state level to the various regions); and secondly, mainstreaming (comprising deinstitutionalisation, the relocation of as many patients as possible into their original communities, and the integration of mental health into the broader health system). A Mental Health Task Force developed a two-year plan for integration of mental health services within the region.

Design of the change process

As part of this plan, Facility Z was to be transformed. It would no longer be a large institution, removed from the surrounding community and caring for people with a wide variety of problems. Instead, it would become a much smaller entity, more closely linked with the community, providing acute care, extended rehabilitation services and some specialist care for specific groups. Organisational restructuring was to be implemented by a new senior management team, with responsibility for achieving the "Better Cities" goals of meeting the needs of local communities and providing better services for patients. During the mid-1990s, a steering committee, with representation from regional health services, the Facility and the State Department of Health, was established to oversee institutional restructuring, and a senior management team was charged with its implementation. In early 1999 the hospital had nearly 700 permanent full-time equivalent (FTEs) positions and it was proposed that these would be reduced to approximately 300 positions while retaining its functional structure.

This new senior management team was headed by an Executive Officer (EO) from outside the health system, a self-described "change manager" who elaborated a new "vision", intended to "excite" staff. The main problems the new EO identified with the institution were: generally poor levels of patient care (with some exceptions), a history of industrial confrontation and a mainstream organisational culture that was hostile to change (Document A, 1995: 77-85). The main features of the change process were to be: the formation of "business units" and wards based on clinical need; devolution of decision-making to units and wards; reduction or closure of some units and wards, with

corresponding relocation of patients; new consultative and communication mechanisms, including briefings to staff by senior management, newsletters and information kits on the restructuring; exchange visits between clinical staff in the Facility and in the various regions; and, training on communication and institutional reform for supervisors and middle managers (Document A, 1995: 86-90).

Eventually, a new facility would be built adjacent to the old institution to accommodate the remaining patients and staff. The senior management team was at great pains to stress the enormity of the task confronting them: buildings in an "appalling" state, low staff morale, inadequate clinical practices, and patient care. In reflections written on this period, the EO also stressed the need to reduce the role of unions in workplace organisation. The institution was described as a "hotbed" of industrial conflict, with a pressing need for a new, more "positive" industrial relations climate. To this end, senior management sought to communicate their new vision to staff through a series of mass question-and-answer sessions, designed to build a sense of common purpose firmly within the unitarist tradition of management. The change management process followed a textbook campaign of seeking to win over staff, through such methods as: senior management becoming more visible (for example, by visiting wards and eating in the canteen); the fostering of "change champions" among staff; an emphasis on accountability; and, the claim that management would maintain a "hands-off" approach to areas of professional responsibility, such as clinical practice (Document A, 1995: 86-90).

A simple dichotomy was presented between "the remnants of a paternalistic and even custodial approach" and "the champions of change whose energy is destined to be harnessed". The dynamism of the senior management team was contrasted consistently with the "inertia of those reluctant to change". Importantly, though, job redesign and early retirements had opened up senior and middle management positions, to be filled by people "aligned to the new ideology" from both outside and within the institution. The new EO also introduced a formalised "reward and punishment system", encouraging a significant number of disciplinary procedures, stressing "the need for tough decisions and respect as opposed to being liked" (Document A, 1995: 87-102). The EO sought to ensure that the senior management team all sang:

> ... the same tune, they all had the same words, hence a positive, united vision was espoused, and accepted by many. Everything that I wrote and said to staff had the same message. "No-one will lose their job and we were here to deliver the best service to the most severely mentally ill" (Document A, 1995: 86).

However, many of the staff had their working lives radically altered through relocation, deployment or Voluntary Early Retirement (VER). Approximately 40 were listed as accepting VERs after the selection process was completed and approximately 30 staff resigned in the early stages of the selection process. The reasons for resignation are not available.

It was in this climate that a transition team was appointed to manage the restructuring process. The process was to include relocation of patients and reduction of staff numbers through relocation, deployment or retirement, and the establishment of career counselling, financial and retirement planning for staff. A Human Resources and Change Management Plan (1999) delineated the parameters of the change process. This plan encompassed: strategies for change (including consultation, communication, staff counselling and assistance), the various options for staff (including "matching" staff to the requirements of the new facility, a closed "merit selection" process, selection for positions not filled by this process, deployment and assistance for deployees, and grievance procedures), staff training and development (including career planning and retraining), and VER (Document B, 1999).

The options made available to staff were redesignation, transfer and/or redeployment within the new facility, a relocated mental health services or to another government department. The "matching" process was designed to cover those situations where the same number of eligible staff, or fewer, applied for a set number of positions. The closed merit selection process was to apply in those situations where the number of staff applying for particular positions exceeded the number of positions available. The deployment process was intended to assist "surplus employees", unable to obtain positions in the new facility or in regional mental health services. The outcomes of this process were to be deployment elsewhere in health services or government departments, redeployment to a position at a lower level in the relevant services or departments (at the employee's request) or voluntary early retirement. It should also be noted that, during the overall change process, several personnel changes occurred at the EO level and among senior management.

Therefore, a quite systematic framework for change was established, as part of a planned process of top-down change, informed by recent managerial theory on restructuring, downsizing and the nebulous concept of "transformational leadership". Yet how well did it work in practice? This question is addressed in the following sections of the paper.

Research methods

The paper now reports preliminary findings from data collected during 2000 and 2001, using a range of interview techniques and a survey. This approach was necessary due to the complexity of the research site and the change program being implemented. The purpose of the interviews was to gain an understanding of the problems faced by the architects of change as a result of the organisation's traditional goals and culture. Additionally, the interviews were intended to shed light on problems faced by employees, not only as a result of the downsizing and relocation of staff and patients but also due to the process chosen for restructuring the facility.

First, twelve focus groups were conducted to gain a sense of the major issues facing staff. The focus groups were conducted after the selection process when first round offers of employment within the hospital had been made. These focus groups were followed by a number of interviews with the managers of the change program and those who implemented their policies. A set of 12 interviews with past and present union representatives and union members was also conducted. These unions covered nurses, artisans (carpenters, plumbers, electricians, painters, mechanics), clerical and administrative staff, cleaners, kitchen staff, laundry staff and gardeners.

The second aspect of the research involved an extensive programme of semi-structured interviews aimed at gaining an understanding of employees' experiences of the change process. The interviews covered employment history and status, views on restructuring processes, job design and knowledge and skills. Twenty-four interviews were conducted with nurses, administrative staff and support staff over a period of 18 months. The interviewees were first selected by random approach by the project's research assistant. These interviewees were asked to nominate others who might be willing to discuss their experiences. These interviews do not represent a representative sample, however, they produced a wealth of qualitative data, including employees' personal stories of their work experiences at what had been a relatively closed and stable environment, with some employees having worked on-site for over 30 years. At the time of interview, 13 of the interviewees had been successful in gaining employment in the new hospital, three had been deployed to other facilities, one had accepted a VER and the remaining seven interviewees had deployee status (meaning guaranteed employment), but did not know where they would be located within the health system.

The third component of the research was an employee survey. A confidential self-report questionnaire was distributed to all staff at a time when the majority of those who had not received jobs in the restructured organisation had left the workplace. The questionnaire elicited information on employees' personal details (age, years of experience, gender), mental health and burnout.

The purpose of the survey was to gain a preliminary assessment of the impact of the changes on the health and well-being of employees. Psychological health and burnout were chosen as variables of interest because evidence suggests that health care professionals in particular, have a high risk of developing problems in these areas. This risk occurs due to the people-oriented nature of their jobs, which often involve charged interpersonal interactions centred on their client's problems and needs (Lu, Shiau and Cooper, 1997). Research suggests that elevated levels of burnout and psychological ill-health can lead to deterioration in quality of care or service, increased absenteeism, increased job turnover, absenteeism and low morale (Leiter, 1991). The antecedents of burnout and occupational stress have long been debated in the literature but there is considerable evidence indicating that organisational variables have a significant impact (Schaufeli, Masalach, and Marel, 1993). Of these organisational variables, issues that change in the course of restructuring, such as uncertainty, role ambiguity and workload, seem to be particularly important.

General well-being was measured using the 12-item version of the General Health Questionnaire (GHQ) developed by Goldberg (1972). This general screening test is widely used in stress research, particularly in nursing populations, to detect minor problems with stress and general well-being and covers levels of confidence, depression, sleep loss and problem solving. Respondents were asked to estimate how often they experienced 12 different positive and negative psychological health symptoms, using four response options provided for each question. Burnout was measured using the Maslach Burnout Inventory (MBI) (Maslach and Jackson, 1981). Within this scale, burnout is characterised by three distinct but interrelated dimensions: (1) emotional exhaustion, (2) reduced personal accomplishment, and (3) depersonalisation. The instrument does not measure the presence or absence of burnout; rather, experienced levels of burnout fall on a continuum. Four hundred and fifty questionnaires were distributed to staff in each section of the hospital. Attempts were made to speak personally with all full-time employees in the hospital to explain the purpose of the survey and to hand them a questionnaire.

Perspectives on the change process

Drawing on out different sources of data, we sought to identify three stakeholder perspectives – management, unions and employees – on four main aspects of organisational restructuring in Facility Z: 1) communication and consultation; 2) the selection process; 3) industrial relations; and 4) career paths.

1. Communication and consultation

Management perspective

From the commencement of the project an oversight committee, which included union representation, was formed to act as a mechanism of communication and consultation. Interviews with members of the transition team revealed that effective communication was listed as one of the major challenges they faced when implementing the change. The communication plan included a comprehensive change management plan, regular update newsletter and face-to-face meetings. Indeed, in late 2000 a representative of the transition team was able to furnish the researchers with a large file containing copies of written communication and schedules of meetings. However, this interviewee revealed that, in their view, there remained a small group of staff who would not accept that they would have to leave the hospital.

The consultation process included representation from staff on the design of the new facility. Management interviews suggested that there was a significant amount of consultation in this area and this contributed to delays in completing the facility.

Union perspective

Most union interviewees described communication from management as having been both ineffectual and inadequate. The most negative comments were expressed by union representatives in non-nursing areas, particularly in terms of the communication media (for example, the use of computers, where many staff were not computer literate) and the style of communication (as one respondent put it, "university speak"). The level of uncertainty was seen as the worst general aspect of the process. In the absence of reliable knowledge of the likely outcomes, the worst was invariably assumed, and consultation was seen as tokenistic, at best – performed in order to conform to the letter of the Human Resources and Change Management Plan (1999), and to muster support for senior management proposals. Even at the time of the interviews (August-October 2001), many people were very unsure about the organisation of the restructured institution and their positions (if any) within it.

Employee perspective

Interviews with employees revealed a wide range of views on the effectiveness of the communication process. Responses ranged from "very good" and "great" to "overwhelming and confusing" and "lies and empty words". Analysis of the interview data suggests that although simple, clearly written material was available throughout the process, a number of individuals did not apply this material to their own situation. Interviewees also reported concern for long-term employees whose language and communication skills did not prepare them for such a process. In two cases, employees reported that they decided the course of action they wished to pursue early in the process and therefore regarded much of the information as irrelevant.

2. Selection process

Management perspective

Early management interviews revealed that the transition team recognised a complex set of challenges within the selection process. They needed to: develop a new staffing profile appropriate for the new hospital; design a process that delivered a fair and equitable process but was substantially more time effective than standard public service procedures; and, select staff based on a new model of service delivery. One line manager stated that in his view a new process was necessary as it was generally acknowledged that "the past selection processes were ineffectual".

The selection process deviated from the normal public sector processes for the State. Management interviewees reported that it would have been impossible to undertake the regular practice in any sort of reasonable time frame due to the large numbers of applicants who needed to be processed. However, the oversight committee requested

that the process be slow and incremental, thus giving staff maximum time to adjust to the changes. The chosen process, therefore, involved an application, preparation of a curriculum vitae, nomination of suggested referees (one of whom was a supervisor/district officer), and completion of a test bank that included self-assessment. This was followed by an interview if there were inconsistencies between the methods of evaluation. First-round offers were then made to successful staff. The transition team oversaw the process and case managed those who were not successful in gaining a position. Discussion in 2001 with one of the designers of the change process revealed a belief that the selection process had succeeded in delivering an effective staff profile for the new hospital and new model of service delivery.

Union perspective

All union interviewees, including those who had been allocated their preferred job, criticised the selection process, particularly the use of computerised evaluation of staff. The process was seen as both inequitable and confusing, and unrelated to the abilities of staff members to perform specific roles. All the union representatives expressed concerns that there remained a very poor "fit" between the work that had to be done and the people available to perform that work. None of them believed that management had conducted an adequate audit of the work to be done, and the available knowledge and skills (although this had been prescribed in the Human Resources and Change Management Plan, 1999). New facilities had also been designed with little input from staff with expertise in the relevant areas, and the change process assumed that certain positions at lower levels were "generic": they could be performed by anyone at that level (for example, gardening staff could readily perform kitchen work). This has meant that, in practice, many people have been relocated to particular positions with no knowledge or experience of the specific requirements of those positions.

All the union representatives reported that morale had reached its lowest point during the period of selection and redeployment. This period, which they saw as indicating the peak of uncertainty, lasted approximately six months during 2000. The union representatives also stated that morale had improved somewhat since then, largely due to an end of the period of highest uncertainty. However, they still saw morale as historically low, with most people (including union representatives) adopting a fatalistic attitude towards the planned organisational change.

Employee perspective

The selection process proved to be the most controversial aspect of the decentralisation and downsizing. Again, views provided about the performance of the transition team staff were generally positive. This was evident in views expressed by interviewees on the individuals involved in case management (such as "very good" or "case managers

were excellent"). Yet a number of interviewees put forward the belief that the team was basically there to "serve the organisation, not the staff". A number of employees did not use the services of the transition team, reporting that they could handle the process themselves.

Several of the evaluation techniques included in the selection process were very controversial. Some employees provided very personal accounts of the process and their distress at being unsuccessful in gaining a position. However, there was also a general recognition that the process of selecting staff for the new facility was bound to be an extremely difficult job. There was no consensus on whether the selection process resulted in the most appropriate selection of staff. Reactions ranged from "amazed" to "no surprises" at the outcomes.

A number of the issues raised were related to the perception of fairness. First, the ability of people to understand the process and participate fully if they did not have computer skills was questioned. Second, there were reports of procedural problems at the time of conducting the testing – for example, being advised of the wrong testing time. Third, the "self rating" part of the process was identified by many of those interviewed as problematic. Interviewees reported confusion as to how highly they should rate themselves - a natural tendency to under-rate and some misunderstanding of the questions. For example, some employees were unsure whether rating themselves on report writing meant an incident report or a major internal report. One interviewee stated, "I have a friend who I know works very well, and she rated herself badly compared to how I rated myself".

The fourth area of contention was the selection of referees. There was disquiet at the referees being anonymous. Also, some interviewees believed that those with whom they were competing for jobs were rating them, thereby opening the process to potential abuse. There were also reports of staff being asked to rate the work performance of a person with whom the rater had little recent contact. Fifth, there was a frequent belief that a person's skill and competence as a practitioner, qualifications and past record should have been taken into account. Sixth, there was a general lack of understanding of how jobs were allocated and people placed within the Facility. Finally, there was an expression of disappointment by some interviewees that the process had not allowed them to present themselves in the best possible way.

3. Industrial relations environment

Management perspective

Although the EO who initiated the change management plan had sought to reduce the role of unions considerably within Facility Z, those managers spoken to as part of this research were considerably more conciliatory. During the change management process, senior management had become frustrated with the pace of discussions with the

institution's local union officials. This had prompted the eventual intervention of State union officials, who subsequently conducted much of the negotiations. Currently, there is no substantial evidence of an anti-union management agenda. Indeed, several managers (some of whom are former union representatives) expressed the need to work with unions in a pluralist fashion. They also saw the nature of the work done within Facility Z (for example, the need for security) as encouraging union membership and activity – this situation, they suggested, was unlikely to change in the foreseeable future.

Union perspective

There was general acknowledgment by interviewees that the management-union relationship had shifted from confrontational to consultative. However, a change at the senior management level, including a new Executive Officer with a mental health background, has apparently been significant in this respect: the new senior management team is perceived as more ready to work with the unions. The restructuring process has also encouraged greater cooperation between the unions, especially between the two largest unions on site, a nurses' union and a generalist union, despite their history of ideological and personal antagonisms.

Employee perspective

During the semi-structured interviews, staff were asked about their view on the various unions' contribution and performance. Both union and non-union members were interviewed. As with all other aspects of this study, a range of opinions existed. Comments ranged from "worked hard in the beginning" and "didn't have much impact though they tried" to "very ineffective". Although a couple of interviewees were able to identify concessions won on their behalf by the unions such as "staff not being required to relocate their place of residence to gain new employment", few interviewees were able to identify measures taken on their behalf.

4. Career paths

Management perspective

Early management interviews and the Human Resources and Change Management Plan (1999) recognised the disruption to career paths for many employees, particularly those who did not gain employment in the new hospital. Interviews with members of the transition team generally acknowledged "the end of an era" particularly for support staff such as those who worked in the sewing room and in some specialised maintenance areas. Transitional arrangements included career planning and job seeking skills courses, and, eventually one-on-one case management. In some cases employees embarked on new careers within Facility Z.

Union perspective

The union representatives identified several groups of employees with no apparent career paths. There have been few attempts to utilise and develop existing formal and informal skills. Further, due to the cultural shift away from a "job for life", there is now the possibility of chronic staff shortages, especially among nurses: turnover is highest among those who have arrived most recently. Several of the union representatives were also aggrieved that cuts in numbers of operational staff were not matched by equivalent cuts in managerial and supervisory positions (which have been reduced very slightly in number).

Employee perspective

The impact on employees and their career paths depended on their occupation and their success in the selection process. For some staff the impact of the change was minimal. However, very personal accounts of careers cut short emerged from the interview data. For example, the position of assistants in nursing and the sewing room were no longer required in the new facility. These staff faced relocation, retirement or re-training. Again a range of experiences were described by the employees, although at least three of those who changed positions within the new hospital framework reported a lack of appropriate training for their new roles. Further, at the time of the interview (before the implementation of the new approach to service delivery) these staff expressed the view that their new jobs weren't as satisfying as their old positions. For example a sewing room employee reported "the good thing about the sewing room was we could always do those extra special things for the patients ... now I can't". Similarly, a residential service officer stated "I used to have a lot of patient contact in my job, now its meetings and red tape".

Outcomes of the change process on employees

As well as providing the opportunity to analyse the downsizing and decentralisation processes from a variety of perspectives, the research project provided the opportunity to investigate the impact of these processes on staff. Although it is clear that the change processes will impact in a variety of ways on staff and the organisation, a primary aim of the research was to assess the impact of restructuring on employees' health and well-being. Within this process the data indicated the presence of many of the elements of a "survivor syndrome" outlined above. The following section elaborates on these findings.

Employee health and well-being

The major tool used to examine health and well-being was a questionnaire survey distributed to all employees. Two hundred and sixty-one employees participated in the questionnaire component of the project (a response rate of 58 percent). Respondents were aged between 22 and 67 years (mean = 43) and the most common response for length of tenure was 1-5 years. Approximately equal numbers of males and females responded to the questionnaire. The majority of respondents were full-time employees. The data was examined using SPSS.

Psychological health (GHQ)

When respondents were asked about their level of general well-being, the majority reported feeling positive about their day-to-day life and their ability to face up to any problems. It is important to note that these questions did not differentiate between work and home life as the scale looks at respondents' general attitude to life as a whole. Given that the questions refer to such things as "normal day-to-day activities" and "playing a useful part in things", however, it seems reasonable to assume that employees included their work life in these general statements. Thus, the conclusion can be drawn that the majority of employees felt reasonably content with their ability to function at work.

This conclusion is supported by employees' responses to specific questions about their level of ill-health symptoms. Only a minority of respondents indicated that the ill-health symptoms itemised in the scale were indicative of how they had been feeling. Furthermore, when the scale items are viewed together, 56 percent of respondents reported high levels of well-being and 35 percent reported moderate levels of well-being.

Burnout

Emotional exhaustion: The emotional exhaustion subscale of the MBI measures feelings of being emotionally overextended and exhausted by one's work. The mean of this 48-point subscale was 23.1 (sd 7.9), which is the highest of the three subscales. When looking at the items individually, it is clear that the majority of respondents disagreed or felt indifferent about statements indicating emotional exhaustion. Nonetheless, almost one in four employees felt drained from work and reported working too hard to satisfy others at work.

Depersonalisation: This subscale represents the tendency to individuate and dehumanise others, which, in extreme cases, manifests in a cynical and negative attitude towards others. The mean of this 48-point sub-scale was 18.3 (sd 7.8), which suggests that although some staff reported feeling moderate to high levels of burnout, this is not

manifesting itself in a negative attitude to clients. Less than 11 percent of all respondents agreed with any statement suggesting a hardening towards people and/or recipients of their care. Indeed the item that most respondents disagreed with was they "treat some recipients like they are impersonal objects".

Personal accomplishment: The personal accomplishment subscale measures feelings of competence and successful achievement of one's work with people. The mean of this 48-point sub-scale, which is reverse scored, was 22.3 (sd 7.6). When examining the individual items, it is evident that most respondents had a clear view that they performed effectively to meet the needs of recipients. Many employees, however, thought the organisation did not value their contribution. This view did not seem to impact on employees' attitudes towards recipients of their care or service. Indeed, most people indicated that they thought they had a positive influence on their recipients (these recipients could be hospital clients or staff).

Although it seems reasonable to conclude from these figures that most employees at Facility Z do not report high burnout or elevated ill-health symptoms, it is important to note that the results presented here are higher than those found by the researchers for other health care workers in the region (see Martin and Jones, 2000; Pisarski, 1999). Clearly, the dimension of most concern is emotional exhaustion, with almost 60 percent of respondents reported moderate to high burnout on this subscale. When looking at the scale items individually, a clearly expressed view was that many employees think the organisation does not value the contribution they make.

Evidence of survivor syndrome

The interview data paints a picture of a painful time at Facility Z. As outlined in the employee perspective above, there were polarised views on the fairness of the process. However, the length of time involved in the process, where both survivors and victims remained employed in the work situation, was problematic for many. Both those who had been successful in gaining jobs and those who had been unsuccessful described the transition period as extremely difficult. For example:

> *Successful applicant: Very hard...we have some very upset people here ... they're disappointed, they're angry ... . It would have been better for those who didn't have jobs. If they have new jobs for them, they would have said "OK, Monday you go to your new job".*
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> *Unsuccessful applicant: I think at the beginning I was angry...a lot of people who got jobs have been keeping the psychiatrists very busy for a couple of years. They're de-compensating. They're not confronting the issues with themselves ... by dealing with things, I see things differently.*

Although the original change management plan, in consultation with the unions, endorsed a slow and incremental change, the interviews revealed that the transfer and deployment process was excessively long and protracted. Some people "hung on" in

the hope of eventually gaining jobs in the new facility. Indeed, for some people this strategy was successful. However, the slowness of the outplacement services and the delays of transferring patients and staff to other hospitals confounded the change process for individuals and the organisation. Interestingly, lack of transparency in aspects of the selection process allowed some staff to attribute blame for failure to gain positions in the new facility to the process rather than to individuals. It is possible that this provided some cushioning in the survivor/victim relationship.

Organisational restructuring: some preliminary observations

This paper has provided an overview of the change management process in a large Australian mental health institution and has reported on the widely differing perceptions held by managers, unions and employees of this process. When making some preliminary observations about Facility Z we should point out that it was an organisation that *had* to change – and very few staff disputed this point. It had remained, to a significant extent, a nineteenth-century institution in the final decade of the twentieth century. External forces for change, particularly a reorientation of State and Commonwealth mental health policies towards regionalisation and deinstitutionalisation, had become virtually irresistible. Therefore, this paper has been concerned with the effectiveness of the change management process itself, in relation to the outcomes for three main stakeholders – management, unions and employees.

In doing so, it has identified several substantive problems. First, the "transformational leadership" approach to change that was initially implemented in Facility Z, whereby senior management explicitly stated that their agenda would be the only one, did not lend itself to meaningful consultation and communication. The Executive Officer postulated a simple divide between supporters and opponents of change, the latter to be dismissed as remnants of the old order. Consultation and communication mechanisms, therefore, were viewed with considerable scepticism by many employees (a perception that was compounded by the use of communication media unfamiliar to many employees). A subsequent change in senior management, however, has ushered in a more pluralist management agenda, which appears to have been more successful in placating employee and union concerns.

Second, the slowness of the change process heightened the levels of uncertainty felt by staff. Interview data revealed that some staff felt correspondingly marginalised, adding to a widespread sense of fatalism. The knowledge and skills (both formal and informal) possessed by staff, especially at lower levels, were often overlooked and could have been used more constructively when re-designing jobs and developing the new facility. This might have been achieved by a more thorough audit of work to be done, and of employee knowledge and skills, as proposed in the organisation's Human Resources and Change Management Plan (1999).

The uncertainty experienced by staff was compounded by a selection process that many of the employees interviewed and union representatives (both survivors and victims) viewed as neither fair nor equitable. Interviewees stated that they found it confusing, particularly the lack of transparency in matching the skills required of a particular job with those selected to perform them. The legitimacy of its outcomes was consequently undermined. There is clearly a need for future selection processes to be more transparent, comprehensible to the participants and related to the skills and abilities required for the position and possessed by the applicant.

While these problems had significant detrimental effects on staff morale (as identified by a considerable majority of respondents), morale does seem to have improved under the new senior management. A more consultative industrial relations climate has assisted considerably in this respect: while the roles of the organisation's different unions have changed, the relationships between management and unions and between the unions themselves appear to be improving.

The small size of the new hospital means the new establishment will not be able to provide the number and range of career paths available through the large internal labour market of the old hospital. There is little doubt that specialised skills were lost during the process. The extent to which displaced individuals were able to establish new careers is part of the next stage of this research project.

Not surprisingly, given these results, burnout and mental well-being is a problem for some employees at the Facility. It is important to note that participants reported higher levels of psychological ill-health than those in similar occupations in the region but it is unclear at this stage whether this result can be attributed to the change process. Some employees are clearly experiencing problems, however, particularly in regard to emotional exhaustion. Subsequent evaluations, completed when the new facility opens, will shed light on whether employees' mental health continues to decline or improve, thus allowing more concrete conclusions to be drawn about the impact of the change process on them. At this stage, however, it is fair to conclude that some worrying signs are evident and as such further investigation and intervention are needed.

There is little doubt that a significant cultural change has occurred: the era of a "job for life" has ended. Yet management, unions and employees have still to deal with the consequences of the change management process. Both survivors and victims expressed considerable concerns with a number of problems, as outlined in this paper. While the restructuring process was no doubt necessary, it could have been implemented with less damaging outcomes. Nonetheless, there are signs of a more pluralist, consultative approach to management and union organization that may achieve future change with less uncertainty and anxiety. This paper has delineated some of the main areas that should be addressed if such an approach is to be achieved, and these will be examined in greater detail in future papers.

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