Laurentian University

Advanced Thesis
presented at
Laurentian University
as partial requirement
of the Master of Social Work Program

by

Brenda Quenneville

Walking Recovery Talk: Mental Health Organizational Change

March 12, 2014

Thesis/Advanced Practicum Review Committee
Comité de soutenance de thèse / Stage spécialisé
Laurentian Université/Université Laurentienne
School of Graduate Studies/École des études supérieures

Title of Thesis/Advanced Practicum: Walking Recovery Talk : Mental Health Organizational Change
Titre de la these / stage spécialisé

Name of Candidate / Nom du candidat: BRENDA QUENNEVILLE

Degree / Diplôme: MASTER OF SOCIAL WORK

Department/Program / Département/Programme: SOCIAL WORK

Date of Approval / Date de la soutenance: MARCH 30, 2014

APPROVED/APPROUVÉ

Examiners/Examinateurs:
N/A

(First Reader/Supervisor/Directeur(trice) de these / stage spécialisé)
DANIEL CÔTÉ, PhD, RSW

(Second Reader/Co-supervisor/Co-directeur(trice) de these / stage spécialisé)
STEVEN KUSAN, PhD

(Committee member/Membre du comité / stage spécialisé)

Approved for the School of Graduate Studies
Approuvé pour l'École des études supérieures
Dr. David Lesbarrères
M. David Lesbarrères
Director, School of Graduate Studies

ABSTRACT

The full experience of mental illness cannot be described in isolation from the context in which one lives, yet the internal physical manifestation of symptoms has been the focus of treatment in western cultures. The "recovery" paradigm is emerging as best-practice philosophy for mental health practice and represents a significant departure from existing standards thereby challenging mental health organizations to re-negotiate their relationship with the dominant bio-medical model. Despite the growing acceptance of recovery philosophy, literature exploring large-scale recovery-oriented organizational change is sparse. The purpose of this research was twofold; 1) to outline the steps taken by change agents within an organization embarking on recovery organizational change, and 2) to understand the experience, including successes and challenges associated with change. The qualitative data obtained from interviewing seventeen participants revealed the impact of organizational contextual factors, leadership and communication on recovery organizational change. Further, the data exposed the complexity of challenging preconceptions and practice when trying to adopt recovery approaches. The findings may guide other community based mental health organizations in their recovery journey.

ACKNOWLEDGEMENTS

I humbly acknowledge my privilege to have the resources and support to achieve a Master's level education. It is a product of my privilege that this MSW came to fruition – not just hard work. For example, I never once had to worry about how I would feed my children or experience violence in my home. Since I didn't have to worry about such things, I was able to dedicate the time and energy required for this education. The MSW is also a product of all-important emotional support. In that vein, I offer my deepest and sincere gratitude to the following:

- Dr. Daniel Côté, my first reader, for his patience and knowledge. I truly loved learning from you.
- Dr. Steven Kusan, my second reader, for his insightful comments that challenged me to critically reflect upon my work.
- Christina and Jean-Yves Bégin for providing a warm and loving home away from home.
- My dear friends Michelle Deveau-Brock and Jen Gordon; the MSW program brought us together, our weekly walks have been my saving-grace, and our friendship is my treasure.
- My wonderful parents, Norman and Rose Anne Quenneville, and my brother Peter who listened attentively as I rambled on and on about my studies. I am very proud to be the first person in our family line to hold a Master's degree. I hope there will be many more to follow.
- My loving partner Jordan Wyshniowsky; your shoulder holds my cheek perfectly, and is my favourite place to regroup. Thank you.
- My amazing daughters, Breanna and Courtney Wilson; I was in awe that though the MSW took a lot of my time away, you understood how important it was for me. I don't know how I got to be so lucky to be your Mom, and dedicate this thesis to you.

Finally a warm thank you to the members of "the agency" who took part in this research.

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

CHAPTER 1:

INTRODUCTION

"…it's the message of hope that I think our SYSTEM can recover." - Participant

The full experience of mental illness cannot be described in isolation from the context in which one lives, yet the internal physical manifestation of symptoms has been the focus of treatment in western cultures. The underlying assumption is that a person needs to be "fixed" and re-inserted into society. The social contextual influences remain hidden, even though it has been documented that the social, political and economic oppression (or "stigma") of people with serious mental illnesses like schizophrenia, can be far worse than the symptoms themselves (Corrigan, Larson, Sells, Niessen & Watson, 2007; Rockwell, 2011). Given this perspective, it is clear that public systems intended to support people with mental illness ought to address their clients' social, political and economic realities as well as symptoms of illness. Although many community-based mental health organizations in Ontario have been deeply rooted in bio-medical-model dominated discourse (which often neglects such environmental factors), change is in the air. The "recovery" paradigm is emerging as best-practice philosophy for mental health practice and represents a significant departure from existing standards thereby challenging mental health organizations to re-negotiate their relationship with the dominant bio-medical

model (for a comparison of the recovery and bio-medical paradigms, see Table 1). Interestingly, recovery is not only a shift in therapeutic interventions, but it is also shifting mental health policy.

In 2009 the Mental Health Commission of Canada published, "Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada" which identified recovery-based approaches as most favourable and suggested services endorse recovery philosophy (Mental Health Commission of Canada, 2009). Recovery was also being explored in the most recent Ontario mental health and addiction policy (Government of Ontario, 2011). As a result, community mental health organizations in Ontario (as elsewhere around the world) are embarking on fundamental theoretical shifts to become recovery-oriented organizations (Clossey & Rowlett, 2008; Cook, Shore, Burke-Miller, Jonikas, Ferrara, Colegrove, Norris, Ruckdeschel, Batteiger, Ohrtman, Grey & Hicks, 2010; Oades, Crowe & Nguyen, 2009; Piat, Sabetti & Bloom, 2010). Changing an organizations' fundamental philosophical orientation is no small feat. As Thomas and Fraser (2009) so eloquently stated, "[I]t is typically much easier to embrace philosophy than to put it into practice" (Thomas & Fraser, 2009, p. 154). Further, Perkins and Slade (2012) asserted that *authentic* organizational change was needed since many organizations claim to be adopting recovery-values, yet neglect to support recovery practice (Perkins & Slade, 2012).

Organizational change of this capacity is a colossal undertaking of which guidance is essential (Clossey & Rowlett, 2008). Yet research into recovery-specific organizational change is sparse. While there have been attempts to provide concrete step-by-step models for recovery organizational change (Bird, Leamy, Le Boutillier, Williams & Slade, 2011; Perkins & Slade, 2012; Piat, Sabetti & Bloom, 2010; Salyers, Stull, Rollins & Hopper, 2011), 1) the challenges

related to implementation continue to far outweigh the successes and, 2) a model for recovery organizational change has not been articulated.

By interviewing a variety of formal and informal change agents at a community based mental health organization dedicated to recovery organizational change, this study aimed to address knowledge gaps by answering the question, "How did a community mental health organization change to adopt recovery philosophy and practice?" The corresponding research objectives were twofold; 1) outline the steps taken, and 2) understand the experience, including successes and challenges associated with change. The findings may help inform future mental health organizations in their recovery journey.

CHAPTER 2:

REVIEW OF LITERATURE AND THEORETICAL PERSPECTIVES

"…nobody around the table has a complete view of what's on the table, and the only way of getting that [complete view] is if we communicate…" - Participant

2.1 Background information

There is ample evidence that the bio-model paradigm dominates mental health discourse. From contemporary pharmaceutical companies contributing major financial compensation for medication research (Whitaker, 2002); to the investment in bio-medical origins of illness (Ridgway, 2001), the experience of mental illness is often framed within the person and isolated from contextual influences. Bio-medical theory fails to adequately explain how it is that the social impact of "illness" is often described as much more upsetting than symptoms themselves (Corrigan, Larson, Sells, Niessen & Watson, 2007; Rockwell, 2011). Similarly the bio-medical theory fails to explain why the landmark study conducted by the World Health Organization in 1969 found that prevalence rates and degree of severity of schizophrenia vary from country to country where developing countries that lack access to medical treatments fare better than their bio-medical treatment oriented western contemporaries (as cited in Horrobin, 2002; Whitaker, 2002). Recovery, as an alternative paradigm is emerging in research, policy and practice to broaden the understanding of mental health to include the social and environmental impact of the

experience in western societies. Recovery represents a shift in values, social activism, and recognition of sociocultural features of the experience of mental health.

The birth of recovery is unclear. Perhaps recovery is a modern expression of "Moral Therapy" developed by French physician Phillipe Pinel in the late 1700s. Pinel's work was rooted in the belief that the experience of hearing voices was a direct result of social issues, like poverty or loss of love (Whitaker, 2002). Pinel's philosophy had a ripple effect. Across the Atlantic Ocean, Pinel's work inspired William Tuke (Whitaker, 2002). Tuke, a Quaker with no medical training opened a small home of support for people with psychosis in 1796 as an alternative to the deplorable conditions in a York asylum that claimed the life of Hannah Mills (Whitaker, 2002). Tuke's home offered no medical interventions, instead focusing on the inherent worth and rights of its' residents (Carstairs, 1959).

Clossey and Rowlett (2008) suggest recovery has roots in the mental health consumer and survivor self-help movement that has been active as far back as the 1930s (Onken, Craig, Ridway, Ralph & Cook, 2007; as cited in Clossey & Rowlett, 2008). Borg and Davidson (2008) suggested recovery grew from the work of Italian mental health reformer Franco Basaglia in 1987, who criticized mental health care and practitioners for placing their main interest in illness entities rather than in the person experiencing the illness (Borg & Davidson, 2008). Regardless of the exact origin of recovery, many researchers and writers on the subject agree that the formalization of the approach is relatively new to mental health practice (Anthony, 1993; Ridgway, 2001).

Recovery as an emerging trend, buts up against the powerful dominance of the bio-medical paradigm. As Morrow (2013) described:

Despite a well-established research literature that illustrates the ways in which

> mental distress is intimately tied to social inequalities such as poverty, homelessness, racism, homophobia, and sexism, the social and structural determinants of mental health continue to be marginalized in research, policy, and service provision even as debates in Canada about the failings of the current mental health care system abound. (p. 323)

Despite the dominance of bio-medical paradigms, some community mental health organizations are transforming their systems and practices to embrace recovery. Organizational change of that magnitude can be challenging and many complex issues emerge and specific models and tools to support recovery organizational change are few and far between. The purpose of this study was to explore 1) to outline the steps taken by change agents within an organization undertaking recovery organizational change and 2) understand the experience, including successes and challenges.

2.2 Key Terms

2.2.1 Recovery.

Recovery has been used in a variety of mental health contexts which makes it somewhat difficult to operationally define. Many writers suspect that the lack of a formalized definition for recovery is holding the recovery movement back (Ridgway, 2001; Salyers, Stull, Rollins & Hopper 2011; Smith-Merry, Freeman & Sturdy 2011). At the core of recovery philosophy is the belief that most people can grow beyond mental illness and enjoy a meaningful life (Farkas, Gagne, Anthony & Chamberlin, 2005), especially when community empowerment and strengths-based practice are exercised (Clossey, Mehnert & Silva, 2011). In 1993, Anthony articulated this widely accepted definition of recovery to date:

> "[Recovery is] a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness…" (p. 13).

Embedded within Anthony's (1993) definition were two key elements that are further supported by literature; 1) recovery was a highly subjective experience for the person who was living with the experience (Ridway, 2001; Uppal, Oades, Crowe & Deane, 2010), and 2) there were preferred approaches for practice (Borg & Davidson, 2008; Clossey & Rowlett, 2008; Shepherd, Boardman & Slade, 2008) and outcomes (Thomas & Fraser, 2009).

*Recovery as a social process***.**

Conceptualizing recovery as a social process appears to be a relatively new dimension of research focus (Borg & Davidson, 2008) despite the historical success of Phillipe Pinel, William Tuke and Franco Basaglia. Recovery as a social process is rooted in the idea that recovery is as much (if not more) a socially based experience than a medical one (Piat Sabetti & Bloom, 2010; Shepherd, Boardman & Slade, 2008). Socially, mental illness remains a highly stigmatized phenomenon wrought with economic, political and social oppression. Recovery as a social process, then, recognizes the need to reconcile both internalized and external oppression (Clossey & Rowlett, 2008; Ridgway, 2001).

Recovery as a social movement.

According to Onken, Craig, Ridgway, Ralph and Cook (2007) recovery has its roots in the survivor self-help movement of the 1930s. As the movement evolved the rallying statement,

"Nothing about us without us" emerged to underscore client involvement in both decision making and treatment (Clossey & Rowlett, 2008).

As momentum from the recovery social movement and advocacy groups grew, policy vehicles were engaged. According to Piat, Sabetti and Bloom (2010) Canada was the only G8 country that did not have an adequate mental health strategy in the early part of the millennium (Piat, Sabetti & Bloom, 2010). Perhaps in an effort to rectify that fact, the Mental Health Commission of Canada (2009) released "Toward Recovery and Well-being: A Framework for a Mental Health Strategy in Canada." The Mental Health Commission of Canada (2009) identified seven goals, all of which embrace recovery values. Among those goals were, "People of all ages living with mental health problems and illnesses are actively engaged and supported in their journey of recovery and well-being;" and "People living with mental health problems and illnesses are fully included as valued members of Canadian society" (Mental Health Commission of Canada, 2009, p. 6-7). The Mental Health Commission of Canada offered a beacon of hope for recovery transformation in Canadian mental health systems.

In 2011, the Ontario Government responded with the document, "Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy" (Government of Ontario, 2011). The Strategy embraced recovery-orientation with its dedication to addressing stigma within communities, placing the individual with lived experience in the driver's seat for determining the type of service they want, and addressing issues of siloed services (Government of Ontario, 2011). One may expect that mental health systems will be transforming to embrace these new recovery values and practice. The onus may be on mental health systems to embark on complex recovery organizational change initiatives. Ridgway (2001) cautions that not all recovery change efforts are equal as not all mental health organizations are *authentically*

embracing recovery practice despite the fact that recovery has been shown to improve outcomes and overall quality of life (Ridgway, 2001).

2.2.2 Bio-Medical paradigm.

"You know, if my doctor said he needs to see me every month; 'you're doing so well! I'm going to see you every month.' I would think I was dying. I would think he's full of shit and I'm dying." - Participant

The Ontario mental health system has traditionally been dominated by the bio-medical paradigm. The Roeher Institute suggested that within the bio-medical paradigm, illness is assumed to be a biological, medical or genetic condition that can be prevented or eliminated with specific treatment-oriented interventions (The Roeher Institute, 1996 p. 14). The focus of bio-medical interventions is typically on the internal manifestation of experience, and is often viewed as a deficiency or abnormality that must be medically addressed.

To better illustrate assumptions of the bio-medical paradigm, Table 1 provides a comparison of assumptions and values with the recovery paradigm (see below).

Table 1: Bio-Medical and Recovery Paradigm Comparison

Domain	Bio-Medical Paradigm	Recovery Paradigm
Subjective Experience	The subjective experience of a patient is typically not the focus for intervention.	Building an understanding of recovery as a subjective experience is a priority (for example, Ridgway, 2001; Uppal, Oades, Crowe & Deane, 2010).
Hope	Negative messages about prognoses typically accompany psychiatric diagnoses (Harding, Zubin & Strauss, 1987; as cited in Ridgway, 2001) which hinder development of hope.	Encourage an active shift in hope as an important step toward recovery (Ridgway, 2001).
Sense of self	People often referred to as diagnosis primarily, and sense of self beyond that does not factor into care (Clossey & Rowlett, 2008).	Importance in developing an identity beyond diagnosis to promote personal responsibility for recovery (Ridgway, 2001).
Active self-help	Focus is on adjusting to a chronic	Encourage active self-help and

	disability (Ridgway, 2001) and symptom reduction (Deane, Crowe, King, Kavanagh & Oades, 2006).	the development of a sense of purpose (Ridgway, 2001).
Conceptual-ization of recovery	Traditionally as an endpoint (Thomas & Fraser, 2009).	Seen predominantly as a process (Ridgway, 2001) with client-determined landmarks (Thomas & Fraser, 2009).
Conceptual-ization of mental illness	Biological basis for mental health disorders, thereby requiring medical interventions.	Acknowledgement of outside influences like social context, meaningful activity.
Relationship between clients and professionals	Mental health professionals viewed as having expertise that is needed by the client; therefore there is an inherent hierarchy (Clossey & Rowlett, 2008).	Authentic relationships are seen as key to fostering recovery (Piat Sabetti & Bloom, 2010; Sawyer, 2011).
Client choice	Interventions typically based on the knowledge of medical experts.	Person with lived experience also considered an expert.
Position of power	Power resides primarily with medical professionals typically with psychiatrists at the top of the hierarchy.	Clients to be in power wherever possible.
Prognosis	Fairly negative, expecting poor outcomes (Ridgway, 2001), unless there is proper diagnosis and medical treatment (Clossey, Mehnert & Silva, 2011).	Challenge assumption of negative outcomes set out by medical model (Ridgway, 2001).
Who determines Success	Preferred and expected outcomes defined by mental health professionals.	Each client determines what constitutes as their own success (Clossey & Rowlett, 2008).

Where the bio-medical paradigm typically views mental illness as a chronic disability (Ridgway, 2001) and emphasizes symptom reduction as a preferred outcome (Deane, Crowe, King, Kavanagh & Oades, 2006), the recovery paradigm focuses on the development of a sense of purpose (Ridgway, 2001). The bio-medical paradigm will often use recovery to describe an endpoint (Thomas & Fraser, 2009), where recovery paradigm will see recovery as a process (Ridgway, 2001). In the bio-medical paradigm highly trained professional practitioners are considered experts (Clossey & Rowlett, 2008) and enjoy positions of power in the relationship,

whereas recovery practitioners see the client as an expert in their own right (Clossey & Rowlett, 2008) and strive for authentic and power-balanced relationships (Piat, Sabetti & Bloom, 2010; Sawyer, 2011).

2.2.3 Recovery organizational change.

"I think what we realized was we are saying this, we are talking the talk, but we are not walking the walk." - Participant

Perkins and Slade (2012) called for *authentic* organizational change since many organizations claimed to be adopting recovery-values, yet neglected to support recovery practice. Authentic organizational change ensures an honest shift and fidelity to recovery-values and practice. As Thomas and Fraser (2009) so eloquently stated, "[I]t is typically much easier to embrace philosophy than to put it into practice" (Thomas & Fraser, 2009 p. 154). To achieve this authentic change, every aspect of the organization, from values to outcomes must be addressed (Deane, Crowe, King, Kavanagh & Oades, 2006).

Unfortunately, organizational change of this capacity is a colossal undertaking of which guidance is essential (Clossey & Rowlett, 2008). While there have been some attempts to provide concrete step-by-step models for mental health and recovery organizational change (Bird, Leamy, Le Boutillier, Williams & Slade, 2011; Perkins & Slade, 2012; Piat, Sabetti & Bloom, 2010; Salyers, Stull, Rollins & Hopper, 2011) the challenges related to implementation continue to far outweigh the successes.

The bulk of the literature related to mental health recovery organizational change was focused on specific program implementation (Bird, Leamy, Le Boutillier, Williams & Slade, 2011; Farkas, Gagne, Anthony & Chamberlin, 2005; Lehman, Simpson, Knight & Flynn, 2011; Rychener, Salyers, Labriola & Little, 2009; Sowers, 2005). Some authors suggested one or two specific implementation techniques (Hamilton, Cohen & Young, 2009; Oades, Crowe &

Nguyen, 2009; Peebles, Mabe, Fenley, Buckley, Bruce, Narasimhan, Frinks & Williams, 2009). Only a small number of mental health researchers addressed large-scale organizational change (Piat, Sabetti & Bloom, 2010; Shepherd, Boardman & Slade, 2008). The relative absence of broad organizational change discourse within the mental health paradigm may contribute to the challenges facing mental health organizational change agents.

A broad examination of the literature revealed two major themes; facilitators and challenges to recovery implementation.

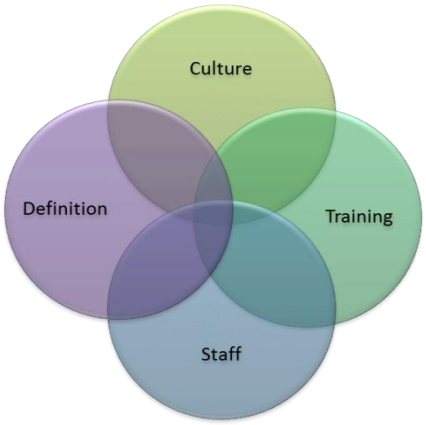
Recovery organizational change challenges.

"…a change of this magnitude takes everybody. It can't be just one person or a group of people. It really requires everybody to be on board or thinking about it." - Participant

Although the vast majority of the challenges identified by the literature were primarily located *within* the organization, Drake and Latimer (2012) identified a significant external challenge. In a comparison of American and Canadian mental health systems, Drake and Latimer (2012) acknowledged two crucial features of the Canadian system that may inhibit recovery-based organizational change. First was a substantial funding disparity between well-resourced medication treatment and the rather sparsely resourced psychosocial services (Drake & Latimer, 2012). In essence, there may be financial rewards for organizations providing traditional medical-based treatments as opposed to recovery-oriented support. Secondly, Drake and Latimer (2012) identified that Canadian psychiatrists (a professional specialization within the bio-medical paradigm) were often remunerated directly by provincial governments. This system would necessarily limit the influence an organization could have in shifting practice approaches with the psychiatrists they employ. Clearly these external challenges will require active policy reform, yet organizations also face a complex system of internal challenges.

Four sub-themes that reflect the internal challenges facing mental health organizations emerged from the literature and are depicted in Figure One. The four sub-themes; 1) staff, 2) culture, 3) definition, and 4) training, represent their own unique characteristics, while also influencing each other.

Figure 1: Internally Located Organizational Change Challenges



Staff.

The literature revealed that it was quite difficult to change practice and attitudes of mental health workers who identified closely with the bio-medical paradigm (Callaly & Ayra, 2005; Clossey, Mehnert & Silva, 2011; Deane, Crowe, King, Kavanagh & Oades, 2006). Clossey, Mehnert and Silva (2011) suggested that accountability was a major contributing factor since recovery required practitioners to release treatment (and therefore outcome) control. Further, Clossey, Mehnert and Silva (2011) identified that our communities as a whole hold mental health organizations responsible for their clients' treatment, increasing pressures of accountability for practitioners. Given the potential consequences in the public space, we can empathize with the hesitation of embracing recovery practice.

Clossey, Mehnert and Silva (2011) also identified how a career in mental health has often been a challenging one. The writers suggested practitioners may find solace in the control the

bio-medical paradigm as opposed to the potential risks inherent in the recovery model. Additionally the lack of professional autonomy had also been identified as a threat to practitioner's expertise (Callaly & Ayra, 2005; Clossey & Rowlett, 2008; Davidson, O'Connell, Tondora, Styron & Kangas, 2006; Deane, Crowe, King, Kavanagh & Oades, 2006; Drake and Latimer, 2012). Some practitioners even viewed recovery practice as professional negligence (Davidson, O'Connell, Tondora, Styron & Kangas, 2006) or perhaps worse, a passing fad (Callaly & Ayra, 2005; Ridgway, 2001).

Culture.

Many authors identified the importance of shifting organizational culture in transforming organizations (Clossey, Mehnert & Silva, 2011; Clossey & Rowlett, 2008; Perkins & Slade, 2012; Piat Sabetti & Bloom, 2010; Whitley, Gingerich, Lutz & Mueser, 2009). While some authors regard organizational culture as adoption of salient recovery philosophies (Clossey, Mehnert & Silva, 2011; Pia Sabetti & Bloom, 2010); others identify the need for a shift in specific internal systems and practices to develop a new organizational culture (Whitley, Gingerich, Lutz & Mueser, 2009). Further, other writers suggest that a shift of organizational culture was a blending of both (Clossey & Rowlett, 2008; Perkins & Slade, 2012). Regardless of the focus for organizational cultural change, the challenges were big, and it was not an easy task, especially when the culture was deeply rooted in bio-medical assumptions.

Compounding the issue of culture, Drake and Latimer (2012) found that organizations with a union may find it more difficult to transition to recovery because union rules were often designed to protect the workers instead of ensuring service provision. Additionally, Raza and Standing (2011) found that organizations where there was a lack of trust or satisfaction between

the practitioners and the management / administrative staff were less likely to engage in the necessary critical reflection processes needed for authentic recovery transformation.

Training.

Staff training was identified as a key activity for organizational change within the literature, yet Uppal, Oades, Crowe and Dean (2010) found that only 37% of the practitioners trained in their study had actually transferred their new knowledge into practice. Despite the high hopes for training to support an internal shift in philosophy and practice, two main factors emerged.

First, Clossey and Rowlett (2008) found that there was a genuine belief among workers that they were already delivering recovery services. Practitioners with this belief may be less likely to engage in critical reflection of their practice and assumptions. Secondly Lammie, Harrison, MacMahon and Knifton (2010) commented on the social desirability of mental health nurses to give the impression of holding less stigmatizing values as compared to their general nursing counterparts. As recovery becomes the buzz word in mental health practice a kind of "professional peer pressure" may develop across professional disciplines. Self-declarations of this sort may contribute to the blurring of medically-based and recovery-based practice, inhibiting knowledge transfer.

Fortunately some help with internalization of training may be found outside of mental health discourse. Kotter and Cohen (2002) are world renowned authors from the business paradigm with the Harvard Business School. Kotter has written extensively on the subject of organizational change. Kotter and Cohen (2002) identified "Increasing Urgency" as the first step in any change process (Kotter & Cohen, 2002, p. 15). The need for urgency holds such value, that Kotter (2008) wrote a book dedicated to that single step. Kotter and Cohen (2002) identified

the common error that intellectual appeals were inadequate to create enough urgency needed for a change effort much like the use of training to transform practice. Instead Kotter and Cohen (2002) suggested tapping into emotional concerns for real change because it was only when one believes a change was absolutely critical will they change. The emotional component was so highly valued to Kotter and Cohen (2002), that at every step in their model they outlined how emotionally appeal can be repeatedly enhanced.

Given the key concept of emotional appeal for change the challenges associated with recovery change and training may be better understood. Training with the target of changing minds and practice will be limiting. To truly internalize change practitioners will be required to critically reflect on their practice, re-evaluate their core values and explore the internal discomfort they will inevitably experience with the shift toward recovery-oriented practice.

Definition.

The lack of a consistent definition of recovery has been identified as a significant challenge for organizational change (Clossey & Rowlett, 2008; Davidson, O'Connell, Tondora, Styron & Kangas, 2006; Piat, Sabetti & Bloom, 2010; Thomas & Fraser, 2009). After all, how can cohesive organizational change happen when there are multiple definitions of recovery being adopted? This issue was eloquently stated by a participant in Piat, Sabetti and Bloom's (2010) study, "…if we don't agree on what we're talking about. Because then we go to meetings and the government puts out reports and we all smile and say: yes, we all want recovery. But we mean different things, and so we move forward, happily doing what we want…because we think we're doing recovery" (Piat, Sabetti & Bloom, 2010, p. 172).

Furthermore Davidson, O'Connell, Tondora, Styron and Kangas (2006) found that working from a firm definition of recovery had the most profound effect on change. Therefore it

is paramount that administrators and change agents take the time to develop the guiding definition of recovery for the organization.

Challenges summary.

The four challenge sub-themes also interact with one another. For example, if an organization were to identify a specific definition of recovery that emotionally resonated with the majority of the staff one may expect more staff buy-in. This platform may support targeted training and thereby influence the overall culture of the organization. Or staff members that were unhappy in their work may be less likely to authentically embrace training, compromising knowledge transfer and deplete organizational culture. Conversely, an organization with an established culture of innovation may have staff whom are more open to training nurturing the recovery shift (Whitley, Gingerich, Lutz & Mueser, 2009).

Recovery organizational change facilitators.

Just as there were multiple recovery organizational change challenges, there were also items revealed in the literature which support recovery organizational change. They included, 1) leadership, 2) communication, 3 teamwork, 4) innovation, 5) training, and 6) practice standards and outcomes.

Leadership.

Leadership emerged as a key factor that supported implementation of recovery within mental health organizations (Anthony & Huckshorn, 2008; Becker, Torrey, Toscano, Wyzik & Fox, 1998; Callaly & Ayra, 2005; Clossey & Rowlett, 2008; Oades, Crowe & Nguyen, 2009; Piat, Sabetti & Bloom, 2010; Raza & Standing, 2011). Indeed, recovery leadership was a growing body of research and discourse where a leader was believed to have great potential to impact an organization (Piat, Sabetti & Bloom, 2010) be it changing the systems within the

organization (Clossey & Rowlett, 2008) or conflict resolution and management (Becker, Torrey, Toscano, Wyzik & Fox,1998; Raza & Standing, 2011).

The development of a specific model of recovery leadership was the focus Anthony and Huckshorn's (2008) book "Principled Leadership." In the book, Anthony and Huckshorn (2008) offered eight tasks and capabilities that describe a principled leader; 1) communicate a shared vision, 2) centralize the mission while decentralizing operations, 3) create a culture defined by recovery values, 4) encourage staff empowerment, 5) continue the development of human technology to support recovery, 6) relate constructively with employees, 7) embrace and encourage ongoing change and evolution, and 8) build their organization around exemplary performers (Anthony & Huckshorn, 2008).

Communication.

Clear, effective and saturated communications of new values were found to be crucial for authentic organizational change (Deane, Crowe, King, Kavanagh & Oades, 2006; Kotter & Cohen, 2002). Communication was critical whether it was used to alter the organizational culture (Clossey & Rowlett, 2008) or in combating resistance (Callaly & Ayra, 2005). Further, Callaly and Ayra (2005) suggested that communication of recovery values ought to be linked with the individual change process practitioners witness in their clients.

Teamwork.

Thomas and Fraser (2009) examined factors associated with implementation of a specific Supported-Employment program within an existing mental health organization. They found that fully-engaged commitment and teamwork from all levels of the organization (not just with the leaders) was central to the successful implementation of the program (Thomas & Fraser, 2009). Thomas and Fraser (2009) suggested strong teamwork enabled staff to support each other

through the critical reflection of their practice. Critical reflection as a team required strong internal teamwork and commitment to change.

Innovation.

Establishing an organizational culture of innovation was shown to be an important contributing factor to successful implementation of recovery (Whitley, Gingerich, Lutz & Mueser, 2009). By adopting a culture of innovation, staff and the organization as a whole were both accustomed to, and accepting of change (Clossey & Rowlett, 2008; Shepherd, Boardman & Slade, 2008).

Training.

Though less than satisfactory training outcomes were identified as a challenge in the literature, training was also believed to be key in changing, 1) practice (Deane, Crowe, King, Kavanagh & Oades, 2006), 2) the organization (Becker, Torrey, Toscano, Wyzik & Fox, 1998; Whitley, Gingerich, Lutz & Mueser, 2009) and, 3) the culture (Peebles, Mabe, Fenley, Buckley, Bruce, Narasimhan, Frinks & Williams, 2009; Thomas & Fraser, 2009). To aid in the transfer of knowledge from training Becker, Torrey, Toscano, Wyzik and Fox (1998) recommended the development of clear guidelines and expectations coupled with ongoing, quality supervision. In this context organizational change agents must not assume that recovery training will achieve the outcomes they desire in isolation from administrative and managerial support. Unfortunately there was a gap in knowledge related to overall knowledge transfer to practice and may warrant future consideration.

Practice standards and outcomes.

Traditional medical-model based treatment standards were not sufficient for recovery practice. Therefore there was increased need to develop new professional standards (Perkins &

Slade, 2012; Piat Sabetti & Bloom, 2010). Those organizations that established new standards for practice were generally found to be successful (Piat, Sabetti and Bloom, 2010; Smith-Merry, Freeman & Sturdy, 2011). For example, Smith-Merry, Freeman and Sturdy (2011) endeavoured to identify the key recovery "technologies" (practice standards) that contributed to successful recovery implementation across Scotland. Through the evaluation of a wide variety of documents and qualified by interviews from a variety of stakeholders, the researchers were able to identify four new standards for practice; 1) narrative approaches, 2) the Scottish Recovery Indicator, 3) Wellness Recovery Action Planning (WRAP), and 4) peer support. Smith-Merry, Freeman and Sturdy (2011) suggested that without formalizing new practice standards and developing a means to uphold those standards through accountability, the risk of slipping back into old practice habits were high. Establishing desired practice standards is an important task for administrators and will require revisions to mission statements, record systems and quality assurance systems (Becker, Torrey, Toscano, Wyzik & Fox, 1998; Farkas, Gagne, Anthony & Chamberlin, 2005; Sowers, 2005).

Summary.

The literature suggests that recovery organizational change is facilitated by leadership, communication, teamwork, innovation, training and practice standards and outcomes. In this way, members of an organization are empowered, inspired and are given clear direction on the change needed.

2.3 Theories Relevant to Recovery Organizational Change

Just as the literature identified multiple issues that help or hinder recovery organizational change, so too do some theories broaden the scope of understanding. A brief examination of disability theory and organizational change theory follow.

2.3.1 Disability theory.

Parallels may be drawn between the contemporary recovery movement in mental health and the 1980s deinstitutionalization of people with developmental disabilities. The Roeher Institute in Toronto, Ontario was a leader in disability research and policy development. In 1996 The Roeher Institute published, "Disability, Community, and Society: Exploring the links" (The Roeher Institute, 1996). That key publication offered a continuum of theoretical paradigms to conceptualize disability. On polar opposites of the spectrum were the bio-medical approach and the rights-outcome approach.

Where the bio-medical approach saw disability as a deficiency located *within* the person that needs to be fixed, the rights-outcome approach considered how broader systemic factors inhibited equal participation their communities (The Roeher Institute, 1996). Naturally the incongruent conceptualizations of disability yielded significantly different approaches. Where the bio-medical approach typically favours individual treatment isolated from external factors, a rights-outcome approach would focus on addressing disabling aspects of society and strive to empower all its' members (The Roeher Institute, 1996). Some recovery approaches to mental health bear strong similarities to the rights-outcome approach.

Many recovery writers underscored the need for understanding social factors that influence the experience of people who access mental health services; another similarity with disability theorists. For example Oliver (1990) clearly articulated how the rise of capitalism played a critical role in the contemporary experience of disability. Oliver (1990) asserted that prior to the industrial revolution and rise of capitalist economy, every person despite their abilities, had a vital role in the survival of family and community. Once work was displaced into factories and value was assigned based on one's ability to create maximum output for economic

gain, those who were unable to compete were devalued. As the devaluing continued over time so did the pathologizing role of professionals in the bio-medical paradigm (Oliver, 1990). These factors contributed to entrenchment of disability in the bio-medical framework of personal limitation. Regrettably social factors that emerged from capital gain were concealed (Oliver, 1990).

Further, Cayley and Sinclair (1994) produced a radio documentary for the Canadian Broadcasting Corporation entitled "Beyond Institutions." Lister Sinclair interviewed David Cayley about deinstitutionalization of people with intellectual disabilities. Cayley demonstrated how institutionalization had removed people with intellectual disabilities from the social fabric of communities to such an extent that when people were being placed in community group homes, it was a shock to the community to have them in their midst (Cayley & Sinclair, 1994). Cayley identified how efforts to educate the community to embrace people with intellectual disabilities were paramount.

It has been documented that the stigma associated with the experience of what is medically termed "schizophrenia" is far worse than the symptoms themselves (Corrigan, Larson, Sells, Niessen & Watson, 2007; Rockwell, 2011). Social stigma against people with lived experience manifests in many ways in contemporary society including: barriers to adequate housing, discrimination when seeking employment, limitations to participate in education, social avoidance and limited opportunity to make friends and restricted social service options. Similar to deinstitutionalization of people with developmental disabilities, efforts to reduce oppressive stigma against people with mental health experiences should be included in recovery practice (Clossy, Mehert & Silva, 2011; Piat, Sabetti & Bloom, 2010; Ridgway, 2001).

2.3.2 Organizational change theory.

Examination of literature within both mental health and business management paradigms was required to fully conceptualize recovery organizational change. Table 2 (below) offers a brief comparison between four examples of organizational change. Piat, Sabetti and Bloom (2010) and Shepherd, Boardman and Slade (2008) offer recovery-specific analysis, whereas Peirson, Boydell, Ferguson and Ferris (2011) and Kotter and Cohen (2002) offer organizational specific change theories.

Table 2: Comparison of Recovery Organizational Change Theories

Comparison Criteria	Piat, Sabetti & Bloom, (2010)	Shepherd, Boardman & Slade (2008)	Peirson, Boydell, Ferguson & Ferris (2011)	Kotter & Cohen (2002)
Assumptions	Changing practice will change organization.	Incorporating recovery values will align organization.	Organization is a system of interdependent parts. Change is organic.	People are emotional invested in work and change is unavoidable.
Structure and Orientation (theoretical or action)	Mixed.	Mixed.	Emphasis on relational principles on micro, macro and mezzo levels, over clearly defined steps. Mainly a theoretical approach.	8 Steps for change. Action oriented.
Strengths of model	Recovery-specific. Six needs for micro mezzo and macro intervention.	Recovery-specific. Included organizational guiding principles into discussion.	Emphasis on consideration of past/present and future contexts. Allows final outcome to develop over time. Organic feel to it.	Difference between Change Management and Change Leadership. Strong evidence of real-world applications.

Limitation of model	Not a model for organizational change. Questionable role of leadership.	Not a model for organizational change though did include organizational principles in analysis.	Organic development may be difficult to sustain. May result in loss of focus / drive.	For-Profit orientation. Less emphasis on context of relationship between segments.

Piat, Sabetti and Bloom (2010) focused their inquiry on the perspective of administrators, provincial policy makers and regional planning groups of three Canadian mental health communities who have embarked on recovery organizational change. Piat, Sabetti and Bloom (2010) identified six implementation "needs"; 1) the need to develop an agreed upon definition of recovery, 2) the need for community development to reduce stigma, 3) the need to hold individual service providers accountable for recovery-practice implementation, 4) the need to develop new standards for professionalism, 5) the need to get people with lived experience involved in the organization as a whole, and 6) the need to create new standards and outcome measures to support the change (Piat, Sabetti & Bloom, 2010).

Interestingly most of the administrators, regardless of their level of influence, did not view themselves to be in a position of power to ensure the adoption of recovery-practice. Instead most administrators felt they were limited to providing an organizational structure and context in which such practices could be adopted where the actual adoption of practices remained the responsibility of individual practitioners (Piat, Sabetti & Bloom, 2010).

Strength of the work by Piat, Sabetti and Bloom (2010) lay in the acknowledgement of community development to address oppressive stigma, which would be supported by Ridgway (2001). Similarly, identifying the need for a firm definition of recovery, and the call for development of practice standards and correlating accountability measures also lend strength to this model.

The second example of organizational change was imbedded in an article that was a descriptive analysis of recovery practice by Shepherd, Boardman and Slade (2008). The snippet briefly described the steps META (a small American mental health organization) took to embrace recovery. The impetus for organizational change came when the CEO and some staff of META attended a workshop where a psychiatrist with lived experience described how current mental health practices were highly disempowering and disrespectful despite their intention to help. Shepherd, Boardman and Slade (2008) briefly described five steps META took in their quest for organizational change. They were; 1) a revision of mission statement, 2) commitment to involving people with lived experience in all levels of the organization, 3) a conscious shift from a "therapeutic" model to an "educational" one, 4) hiring of peer professionals (people with lived experience), and 5) a commitment to continued growth intended to build upon their core values and targets (Shepherd, Boardman & Slade, 2008).

The steps highlighted the important contribution of people with lived experience, which is a core value of the recovery philosophy. The steps also captured the need for an educational culture and overall commitment of all levels within the organization. These steps hold promise for the development of a model for organizational change and further examination of their process would likely be helpful.

The following two theories for organizational change were uncovered outside of mental health literature. Peirson, Boydell, Ferguson and Ferris (2011) introduced an Ecological theory for organizational change from a community psychology perspective, while Kotter and Cohen (2002) offer a thoroughly tested business-oriented model.

The Ecological model offered by Peirson, Boydell, Ferguson and Ferris (2011) suggested that organizational change can be imbedded within the four key ecological principles; 1)

interdependence, 2) cycling of resources, 3) adaptation and 4) succession. The model assumed that an organization was a system of interdependent parts and change in one part will affect the organization as a whole. The writers called for a thorough analysis of all the organizational parts prior to embarking upon change.

Though the Ecological model of change was not laid out in a step-wise, linear fashion, it did point to the primary need to develop a thorough understanding of what the change was required. In the case of recovery an agreed upon definition would be essential. Once the direction or definition of change was established, the process became much more fluid. So fluid, in fact that the Ecological model did not assume that there would be a fully articulated end state (Peirson, Boydell, Ferguson & Ferris, 2011), much like recovery as a process. Similar to a personal experience with recovery, organizations may also be ever evolving. Additionally another key activity of the Ecology model was a thorough assessment of the past, present and future of the organization. That perspective may help with re-negotiating an organizations' relationship with the bio-medical model which is necessary for the successful adoption of recovery values.

Strength for Peirson et al.'s (2011) Ecological model is the high compatibility with recovery values and processes and helps to fill the gap left by the mental health literature. The lack of clarity for specific steps may inhibit an organization's ability to fully embrace the Ecological model of change, however.

Finally, a review of Kotter and Cohen's (2002) model for organizational change revealed a clear articulation of change stages, as well as key change activities for each step. For organizational change agents requiring more specific support, Cohen (2005) developed a companion "Field Guide" book that included ideas and exercises to accompany each step.

Kotter and Cohen's (2002) model of organizational change was strongly rooted in the belief that people change because they are shown evidence that appeals to their feelings (as opposed to their thinking only). At each step in the change process, Kotter and Cohen (2002) offered examples for appealing to emotions in an effort to foster change.

The eight steps outlined in Kotter and Cohen's (2002) model were; 1) increase urgency, 2) build the guiding team, 3) get the vision right,4) communicate for buy-in, 5) empower change, 6) create short-term wins, 7) don't let up and finally, and 8) make change stick (Kotter & Cohen, 2002).

Strengths for this model are in its widely researched and practiced contexts and stories, coupled with its well-defined steps for change. The model offers valuable "how to" information to help demystify the process for organizational change agents.

Summary.

Though the mental health literature offers important insights into recovery specific theory, concrete literature guiding organizational change is lacking. Compounded by the complex dominance of the bio-medical paradigm, recovery change agents face an up-hill challenge to embrace some of the *authentic* recovery values. For example, the interplay of staff, training, culture, leadership, communication, teamwork, innovation and the development of new standards and outcomes demonstrate the highly complicated nature of recovery change. On the other hand, generic organizational change literature from the world of business offers valuable models that may provide guidance yet they fall short in articulating some of the more complex factors associated with recovery practice change. Take for example how neither the Peirson, Boydell, Ferguson and Ferris (2011) and the Kotter and Cohen (2002) models fully articulated

how to challenge dominant cultural ideology. Recovery organizational change therefore requires the blending of both streams of knowledge which had yet to be explored.

2.4 Gaps in Current Research

While there was increased interest in recovery health organizational change, mental health research to support these types of projects is sparse. Fragmented items that appear to either inhibit or nurture mental health organizational change are emerging from the research. It was a goal of our research to better understand connecting threads between these complex items through qualitative research designs and develop preliminary guidelines in the hope of supporting these very important system and organizational changes.

2.5 Research Objectives

Given that the recovery paradigm is a relatively new topic in research and practice, it is not surprising that literature exploring large-scale recovery-oriented organizational change is sparse and a number of gaps in the literature exist. Although important factors that support recovery organizational change have emerged, understanding some of the challenges may have been limited by, 1) the sample selection and, 2) the apparent omission of a specific model. Using qualitative inquiry with a theoretically-informed lens, the author included a variety of employees in the dialogue of recovery organizational change. It is anticipated that this research will add to the general knowledge base for large-scale recovery organizational change while providing important theoretical knowledge for other change agents.

A community based mental health organization in Northern Ontario has made a concerted effort to shift their philosophy and practice to embrace recovery values, and were therefore chosen for this research. The purpose of this research was twofold; 1) to outline the steps taken by change agents within the organization and 2) understand the experience, including successes

and challenges, of organizational change. The corresponding research question was, “How did a community mental health organization change to adopt recovery philosophy and practice?”

CHAPTER 3:

METHOD

A qualitative, case-study approach to inquiry was used to explore organizational change at a community-based mental health organization located in Northern Ontario who has made the commitment to recovery organizational change (hereby termed the "agency"). Qualitative research was selected for its usefulness in situations where a broad understanding is required (Buston et al, 1998 as cited in Salyers, Stull, Rollins & Hopper, 2011). A case-study research design was selected for its relevance to applied settings (Creswell, 2007). The philosophical assumption from which the author approached research design and data analysis was primarily ontological in that she believes reality is highly subjective and the direct voices and experiences of the participants must root the analysis (Creswell, 2007). Similarly the author readily acknowledges her strong social constructionist worldview that one's experiences are socially constructed and not at all independent of our interactions with the broader world (based on Creswell, 2007).

3.1 Setting.

Servicing people in Northeastern Ontario, the agency provides comprehensive community-based mental health services to a combined population of 113,756 people throughout 154,570.33 square kilometers. The agency receives its financial support primarily through the Local Health Integrated Network funding of the Ministry of Health and Long Term Care. Mental health services are available at the main site, or in one of the two main satellite offices dispersed across the Northeastern Ontario landscape. The agency also has a women's domestic violence shelter.

Staff members from multiple professions (nurses, occupational therapists, social workers, peer professionals, psychiatrists, etcetera) work in a variety of mental health programming, including conventional case management, housing support, court diversion, assertive community treatment, primary care and peer support. In 2011, the agency embarked on a formal recovery organizational change project in an effort to adopt a stronger organization-wide recovery orientation. As a part of the change project, select staff were reassigned to the "Recovery Change Team" and tasked with researching and developing recommendations for the administration to guide the recovery organizational change efforts. This agency was selected for this case-study because they were committed to the recovery shift and were already underway in the change process.

3.2 Sample.

In an effort to robustly describe the multiple perspectives (Creswell, 2007) of organizational change for the employees at the agency, maximum variation sampling technique was employed. The maximum variation framework targeted four subsets of employees (recovery change team, management team, executive administration team, direct service

providers) from the three main geographic locations. Relevant parameters for identifying participants for 1) the management team were people who had any management or supervisory responsibilities; 2) direct service providers were any employee paid by the agency whose job description requires them to provide direct service to clients for at least 60% of their time.

Purposeful sampling guided recruitment and selection. Participation was open to all employees of the agency involved in mental health programming, and participation was time-limited.

3.2.1 Exclusionary criteria.

To create an open discussion environment in the focus groups, participation in focus groups excluded psychiatrists and medical doctors, since those are typically positions of authority over direct service providers. Similarly members of the management team, administration team or recovery change team were excluded from the focus groups. In an effort to narrow in on mental health recovery paradigm change, employees of the domestic violence shelter and any support staff of the agency were excluded.

3.2.2 Recruitment.

The researcher approached the Executive Director of the agency via email to explore interest in the research project. The initial email contained a brief outline of the project as well as some parameters for protecting participant engagement as per Hilton (2006). For example, in an effort to ensure confidentiality the raw data will not be available to the agency and members of the management or administrative teams (including psychiatry or medical doctors) will not attend the front-line focus groups. The Executive Director endorsed the research project and connected the author with a member of the management team who was assigned to be the agency project lead. The necessary proposal and ethical analysis were prepared and ultimately approved

by the Laurentian University Research Ethics Board in May 2013. The author forwarded the recruitment poster via email to the agency lead contact who in turn forwarded it to all agency managers. Interested participants emailed the researcher, and interviews and/or focus groups were scheduled according to participant availability. Informed consent was obtained prior to each interview or focus group.

In the end six individual interviews were conducted representing two members of the management team, three members of the recovery change team and one member of the executive administration team. An extra focus group was incorporated into the design to include the voice of the two recovery change team project leads that represented a unique perspective not factored into the original research design, but was seen to strengthen the overall research project. In the end, four focus groups were held, with seventeen participants over all.

3.2.3 Demographics.

Of the seventeen participants, four worked primarily from the main office, seven worked from one of the main satellite offices and six were from the second main satellite office. Of the seventeen participants, two were nurses, two were occupational therapists, two were peer professionals, eight were social workers or social service workers, and three were primarily trained in the social sciences (psychology, sociology, etcetera). There was some cross-over in academic orientations, for example a peer professional with psychology degree or a social worker with a social science background, etcetera. Of the seventeen participants, three were male and fourteen were female. The average length of time working for the agency was 8.9 years. There were six participants who had worked with the agency for less than 4 years, four who were employed for 5-9 years and eight who were seasoned employees having been employed for over 10 years. Though it was not designed in this manner, recruitment yielded the

majority of less experienced (4 or less years of employment with the agency) employees in one focus group. Another focus group was comprised of exclusively seasoned employees (both having worked over 10 years with the agency).

3.3 Data Collection

The primary source of data was the collection of in-depth interviews and focus groups, which were voice recorded and transcribed verbatim. Data collection also included the researchers' observations, documents and journals as recommended by Creswell, (2007).

The interview guide was based on six question domains that were guided by the literature review. First, professional orientation was sought based on the findings of Callaly & Ayra, 2005; Clossey, Mehnert & Silva, 2011; Deane, Crowe, King, Kavanagh & Oades, 2006, who suggested that workers who identify closely with the medical model were more resistant to recovery change. Second, recovery knowledge and identification were explored based on the general indication in the literature that multiple recovery definitions are abound and may impact authentic recovery change. Third, given the poverty of data in the mental health literature the researcher inquired into the use of an organizational change model or theory. The literature also indicated multiple items that facilitated and were barriers to recovery organizational change, so items that emerged within those categories were explored. Finally, the interview included time for open-ended discussion in case there were other items that the researcher had not considered that participants felt was important to include.

3.4 Verification of Findings

Creswell (2007) suggested the use of at least two strategies to ensure qualitative research validity (Creswell, 2007, p. 209). This project employed 1) clarifying researcher bias, 2) triangulation, and 3) rich, thick description. To clarify researcher bias, the author maintained a

personal journal throughout the data collection and data analysis process. Following each interview, the author made notes to aid in preliminary analysis, identify gaps or issues for further interview questioning and overall impressions that may be influenced by bias. The data gathered from the interviews were compared to multiple sources of literature (both practical and theoretical) to achieve triangulation. Triangulation was also achieved through the varied perspectives of employees who encompassed four teams within the agency. Data was presented through rich, thick descriptions and using the voices of participants wherever possible. This ensured that the narratives and perspectives of participants were more prevalent than that of the researcher.

3.5 Approach to Analysis of Data

Analysis of data began with the initial journal entries after each interview session to help create the first general impression of the data. The audio interviews were transcribed into written format. The transcribed data underwent two types of data analysis to enable the author to move deeper and deeper into the data (as per Creswell, 2009). Data analysis followed the guidelines set forth by Tutty, Rothery and Grinnell (1996).

First, the data was coded using techniques suggested by Tesch (1990; as cited in Creswell, 2009, p. 186). In this technique, coloured lines are drawn vertically through data to allow the researcher to identify the original context. The data is then "decontextualized" through copy and pasting in other thematic arrangements for consideration. The process is repeated until new themes no longer emerge, suggesting the data is saturated. Each of the themes and related reasoning for groupings were recorded in the research journal for peer debriefing. Though it was evident that the agency was engaging in both philosophical and structural transformation the

author focused on the philosophical change since programming structure change would highly specific to the agency and would lack generalizability to the broader research community.

Second level analysis was executed through the development of a Thematic Relationship Matrix (Table 5). The dominant themes were arranged both horizontally and vertically. At each intersection, the author reflected upon the data, compared it with the literature and assigned designations accordingly (+ for intersections that will facilitate recovery organizational change, - for intersections that are barriers, ~ for intersections that were too ambiguous, nothing for intersections that were neutral, and () for items that had potential for the future). Two themes were selected based on relevance for theoretical analysis, whereby the themes were considered through critical analysis shaped by relevant theories.

The findings will be delivered back to the agency in the format of their choosing (written document, in person presentation or other).

CHAPTER 4:

FINDINGS

4.1 Organizational History Leading to Recovery Implementation

At the time of interviewing at the agency (June 2013), the recovery organizational change process at had only just begun. The presentation of findings will begin with a brief snapshot of what had happened to that point.

4.1.1 Contemplating change.

Just as a person's experience of mental health cannot be completely separated from their social environment, the external context in which the agency is situated presents important considerations for recovery organizational change. One participant noted how the health sector was moving toward chronic care models of health (as compared to acute care):

> …part of our problem structurally is because we are based on an acute care model where hospitals…the funding goes to the more emotive and immediate needs, which are acute needs. Someone has a heart attack, we need cardiac surgeons. …So it's not looking out necessarily why are they having heart attacks. That preventative piece….That lifestyle

> component…acute care really drives up the cost in the short and long term. …And what has been driving health care reform is fiscal crunch…there is more of a political will and resolve to say "no we have to do something about this" which is pretty much where we are at now.

This external shift gave the agency the opportunity to frame recovery as chronic care thereby creating a sheltered space for recovery practice to blossom.

Shifting the gaze internally to the agency, it was clear that there was no single event that marked the start of the recovery organizational change journey. Where one participant felt the change began with a program review project undertaken in 2007, other participants identified a team-specific pocket of intensive recovery training delivered by an external consultant, also in 2007. Still other participants pointed to the May 2011 visit of world-renowned recovery researcher, Mike Slade and the Ontario Peer Lead for the Ontario Common Assessment of Need (OCAN), Susan Marshall. The absence of a single, definite starting point speaks to the organic nature of recovery organizational change at the agency. In one participant's words, "It is like tilling a garden, so preparing some ground. And there's no real end point – it is an evolution."

Other internal contextual factors that may influence recovery organizational change include the introduction of a workers union in 2009; a change in executive leadership in 2010; the adoption of OCAN (Ontario Common Assessment of Need) in early 2011; and the first collective agreement negotiated in 2011.

Most significant to some participants was the transition to OCAN. To help launch the OCAN, British recovery researcher Mike Slade and provincial OCAN peer lead, Susan Marshall were brought to the agency. All staff members, from accounting, information technology, human resources, administration, management and direct service providers took in presentations

at all three locations. Following the larger group presentations, there were smaller group discussions with Mr. Slade and Ms. Marshall. As one participant reflected,

> "And that for me personally was an eye-opener. Like Mike Slade just slashed so many of our take it for granted practices and approaches and I just thought, 'Woah! How did we not see this before?' Ya, so that was a big push forward too."

4.1.2 Creating a team.

"You need the doers because there is a lot that needs to be done." - Participant

The sessions with Mr. Slade and Ms. Marshall inspired some members of the organization to reflect on how to support such large scale change, "…if we don't dedicate some resources to this, this will never work." In early 2012, two recovery change lead positions were created on a short-term contract basis (lasting just over one year). One position was a peer professional, the other, a management representative. Together the two lead positions oversaw the development of specific recommendations that were put forth to the board of directors and senior management team. The two leads were not to work in isolation, however, and a team comprised of family members, people with lived experience, a board member, and representatives from the management and direct service provider teams were brought together to undergo intensive recovery training and exposure. This newly formed recovery change team was born, "…so we could have all of these champions imbedded within the organization to make the changes happen from within."

The creation of a whole new team dedicated to gathering knowledge of recovery service, practice and structure required extraordinary resource re-allocation and support from the board of directors. Fortunately the board of directors shared the vision for the new direction and approved the fiscal support for the project.

4.1.3 Quest for knowledge.

A member of the recovery change team reflected on their task; "… [We] visited several programs around the United States and then brought back some of the ideas, started implementing and started…educating and sharing some of our learning's with the rest of the agency." A participant reflected about the tasks once the change team returned to work;

> …every member of the change team had about 10 people they were responsible for – they had to keep touch with and keep in touch with in case they had any questions about recovery or whatever. It will be their opportunity too to talk about some of the educational things that we took part in while we were away and their experiences and so on…

In this way, the recovery knowledge, passion and experience was infused within the organization. Interestingly there were mixed opinions about the worth of developing the recovery change team and having them undergo such intensive exposure to recovery. As one participant reflected;

> … seeing it in practice and being able to speak with people that really did bring it to life. So for all I said about some of the downsides of having the change team ahead of the curve with the rest of the organization it certainly solidified it and created a sort of bedrock for the rest of the organization….so that was I think really important.

4.1.4 Challenging preconceptions.

Strategies for engaging all members of the organization were employed throughout the year. One example was the language challenge. Members of the organization were encouraged to create teams with people from service provision teams, geographic locations, and include people with lived experience. The challenge was to identify terms and language often used in

service provision, and create new, more recovery-oriented alternatives. All of the entries were judged by a panel of people with lived experience and the winning language alternatives were compiled into a glossary of terms that which all members of the organization were encouraged to adopt.

Other activities included; 1) the development of an agency-wide recovery definition and values, and 2) in depth analysis of peers. Highlighting the nuances of the peer analysis, one participant described, "…what does it mean to have lived experience…what does it mean to be a peer, what is peer support…"

The chief project assigned to the recovery change team was the development of a list of recommended recovery-based changes to be considered for the agency. Great effort went to engaging as many stakeholders in the discussion as possible to develop the recommendations. As one participant noted, the extra effort was worthwhile, "…every voice was listened to and I think we have huge buy in into that vision of the recommendations that went forward."

4.1.5 Making the most of opportunities.

Antidotal evidence from discussions with people in the field state that not-for-profit organizations in Ontario are subject to fiscal dimensions that can impact decision making and planning. With most governmentally funded organizations, the end of the fiscal year brings pressure to spend any unused funding (that may have been safeguarded throughout the year for risk-management) or else risk losing funding in the upcoming annual funding allocation. This was the case with the decision to bring in "Peer Employment Training" (PET) to the agency. In this program, people with lived experience were trained on how to use their lived experience in a supportive and constructive manner, thereby granting them a valuable employment title like "peer professional." The overall consensus was that the PET was ill-timed, because though it

enhanced skills for people with lived experience, it also set up the expectation for employment despite the fact that positions did not exist which frustrated some participants; "Are we creating a false hope and are we creating things so that the agency looks good but it's detrimental to the clients?"

4.1.6 Building momentum.

Enthusiasm for recovery grew and service providers expressed a desire to develop innovative ways of incorporating recovery practice into their work. Influenced by a historical disconnect between teams and locations, a decision tree was developed with the intention to help organize work. Any direct service provider who wanted to try a new project would seek the approval of their manager, who would in turn pass it by the Director of Operations (DOO). The DOO would assign resources and timelines and give the go ahead. Information would also be shared with the recovery change team.

To help bolster recovery philosophy further, an ongoing training module called "Keeping Recovery Skills Alive" was purchased from one of the American programs that which the recovery change team had visited. "Keeping Recovery Skills Alive" is a series of modules designed to help foster recovery discussion at each site. Attendance is encouraged but not mandatory.

4.1.7 Formalizing the vision.

On April 23, 2013 all but one of the over one hundred recommendations were approved by the board of directors. The expressed support by the board of directors sent a strong message to both external stakeholders and internal members that the agency was committed to making a recovery journey. The support also indicated an acknowledgement that change is necessary.

Summary.

There was no single marker to indicate the beginning of recovery organizational change at the agency. Instead the historical process has been quite organic and multi-faceted. Just as an individual does not experience mental health in isolation from their environmental contexts, the agency does not provide services in isolation from their external environment. Work was done to frame recovery in a manner that was congruent with the funding environment that the agency is situated.

To build capacity for the necessary change activities, the recovery change team was created, guided by two leads (one peer professional, one manager). The key tasks assigned to the recovery change team were to 1) gain recovery knowledge through site visits to multiple locations in the United States, 2) facilitate the development of the agency-wide recovery definition, 3) gather and articulate recommendations for the governing body, and 4) begin challenging the internal preconceptions of the organization.

4.2 Analysis of Interviews

To understand the experience of recovery organizational change, including the facilitators and barriers an analysis of the interviews ensued. From time to time, some items were simultaneously a facilitator and a barrier adding to the complexity of recovery organizational change. Table 3 below outlines the major themes that emerged from the data, and compares both facilitators and barriers to recovery organizational change at the agency.

Table 3: Summary of Findings

Theme	Facilitators	Barriers
Contextual Factors		
Organizational history	Returning to roots	Dominance of medical model
Location	Efforts to unify	Lack of teamwork
Community	Responsive community	Creating recovery community
Outcome expectations	History of inadequate	

	measurements	
Innovation	Belief there is passion and innovation	Management balancing tension between maintaining service provision and innovation
Time/workload		Priority setting
Leadership		
Informal leadership	Recovery change team	Concern about having champions
Formal leadership	Trust where there is a relationship	Desire for more relationship
		Management heavy and poverty of leadership
Communication		
Teaching recovery	Recovery change team	Value of recovery change team uncertain
Strategies for implementation	Recovery change team	Email communication confusing
Consistent messaging	Circulation of drafts	Double messages
Challenging Preconceptions		
Recovery definition	Creation of organizational definition	Multiple interpretations and uses
Bio-Medical Model	Recognition of need to change	Many examples of continued dominance
Peer Professionals	Commitment to 50% staff of people with lived experience	Concern about professionalism and job loss
Practice		
Training	Lots of information available	Priority setting
		Not mandatory
Supervision	Pockets	Not available to everyone
		Assumption that needs to be delivered by psychiatry
Language	Overall positive	

4.2.1 Contextual factors.

Building on the internal and external contextual factors relayed earlier, a large community-based mental health organization such as the agency could not possibly undergo major recovery organizational change efforts in absence of the contextual influences. Six sub-themes emerged from the data, 1) history, 2) location, 3) community, 4) innovation, 5) outcome expectations, and 6) time / workload.

History.

Three participants spoke of the influence of the agency's history to the recent recovery organizational change. Interestingly, two participants viewed the recovery organizational change journey as a return to grassroots:

> …when I first walk through the doors in 1985, the organizations' motto was "Helping people to reintegrate back into the community." Befriend and integrate. So I mean when you use words like "befriend" you're almost doing that again now.

This idea was further supported by a participant who reflected upon an experience while exploring recovery in the United States:

> The CEO of one of the organizations we visited came down to speak with us briefly and said, "You know it's funny, I've been in this business for 30 years and it feels like we are coming back to who we were."

Perhaps attributable to having different programs and multiple locations, participants reported the agency has a history of lack of team work. As one participant noted as she reflected upon the program review project:

> …this was the first time as an agency as far as I was aware that we looked critically – we peered into what was previously was kind of private. That prior to that nobody said "How are you doing intake in [your location], and how are you doing intake here?"…there must be one way that's stronger than the other….

Another participant revealed that there continues to be a lack of teamwork; "…there is a disconnect and there is different things going on at different sites…"

Location.

On the one hand, there was evidence of efforts to unify the organization as they moved through this change. A participant stated:

> …one of the things we are trying to do is create some standardization across the organization. So previously the various sites worked…quite independently of each other. I would say from team to team on a site they worked very independently from each other….one thing we've been trying to do is ensure that we function as one – one organism or one organization. And so to do that, we need consistent practices and using a positive way – we need a bureaucratic structure.

Further, another participant noted, "…we all have skills but I think we are working in our own little world and we have so much to share. You know we come from such different backgrounds and experiences and I don't feel we are doing that as well as we could."

That is not to say that all participants shared the desire to move forward as a unified organizational unit. Although a few isolated statements emerged that seemed like barriers to organizational cohesion (for instance, differences in resources available in each location, like public transportation), the most significant barrier was lack of emotional connection between the locations. For example, "What concerns me is cookie cutter. This desire to make each site look the same…the biggest challenge is I don't like what they are doing in [another location]."

Further this participant revealed their perceived personal differences between locations; "… we are more welcoming of the change and we are excited whereas there is a lot of fear [in another location]."

Further compounding the issue, this participant felt there may be preferential treatment when confronted with evidence that other locations are moving forward with recovery activities while they were not:

> And from my experience there is very little communication from site to site… [referring to reading minutes from a meeting that incorporated members from all three sites] it's suggesting that other sites were moving forward faster with specific implementation and guidelines…So there was a little bit of head scratching as to why other sites can move forward but we're not….if they can, why can't we? We'd love to.

The community.

There was sound acknowledgement that mental health service provision as a whole was moving toward recovery-oriented practice as this participant described; "There is a readiness – it seems like that whole transformational shift of the mental health world and probably beyond – society is shifting in ways that are more consistent with a more recovery-oriented approach and there is that readiness." While there was evidence of community support for recovery values (for example the enthusiastic support of a community partner providing public space to display the agency photovoice project), there was evidence that agency practices differ from other service providers; "Working with hospitals or other agencies….we work with them very closely. Even [name of other organization] where they serve the same people that we support here and we have very different approaches…." As this participant reflected on their unique approach to service provision, a sense of pride was evident; "…I had to deal with [name of another community mental health service provider] and I was just like sort of in shock because we have come far…"

The inter-dependent nature of mental health service provision within their social context can also be a barrier as recovery practices are adopted. Many recovery-oriented interventions require community collaboration, so if other community partners do not share assumptions, values or beliefs, there can be conflict. This participant realistically described the potential conflict scenario:

> …that's not going to land well with the psychiatrist in the mental health unit when they are up to their eyeballs and someone comes in and "well I chose to go off [medications]." "Didn't your worker do something?" And [we] get a call on the phone "What the heck are you doing?"

There is a certain amount of risk that the agency is taking with this recovery change project. Many believe that risk is a hallmark of recovery philosophy as service providers actively endorse the autonomy of service recipients (Clossey, Mehnert & Silva, 2011; Ridgway, 2001). Risk emerged as an inevitable aspect of mental health practice as expressed by this participant, "I think that there is always going to be fear of liability." While on the one hand participants recognized the importance of normalizing risk ("You live life, you make mistakes and you get back and sometimes you just need that support"), there was expressed discomfort with how to manage risk. This participant managed risk by careful documenting "…I make sure I document that I've taken as many [risk management] measures as I can…" These expressions of risk are directly related to the social context in which mental health services are situated, and imply social responsibility to control service recipients. This dynamic significantly impacts recovery organizational change.

Outcome expectations.

Since recovery practice represents a significant departure from traditional practice, it follows that outcome expectations may differ. One participant described the shift in outcome expectations:

> And success is actually a good term as well because who's success and who is defining this? …we are finally I think at a point where we are …asking people "what do you think success looks like?"…That I think is a better marker for success than a period of 30 days where a mood is tracked.

Another participant brought forth a unique perspective that provides an interesting insulating factor to support the shift; "Because I don't think we have ever been able to find a measure of success in mental health. Ever. I can remember what a measure of unsuccessful was – hospitalization … we have never known what we were measuring."

Innovation.

There was a genuine belief of innovation and passion of direct service providers expressed; "…when you engage direct service, we have a lot of people who are passionate about what they do and care about what they do … if you give them a little room, they'll do great things." Yet despite this belief, there were significant barriers to innovation. This member of the recovery change team felt that the internal organizational culture was a barrier to innovation when reflecting upon the her learning in the United States; "…change was not a fatiguing factor, it was 'of course we can do better.' …whereas our culture is still at the 'tell us how to do it right and we'll do it right so we can sit back and breathe and relax.'"

The data revealed the management team's (some of whom were also members of the recovery change team) cautious efforts to balance innovation while preserving service provision as a barrier to innovation. One manager / recovery change team member said:

> It can backfire on us. It's hard. It's a delicate balance. …you don't want to stifle creativity and we have had some amazing success stories from people who think outside of the box, but at the same time, there has been times when we are maybe going a little outside our normal practice or our traditional practice and we have a waitlist of 30 people that are requiring services. So we are expending energy resources, staffing, people power on an idea when we still don't have some of the basics down pat.

In this other instance, a similar participant described how the recovery change efforts may be stifled as a result of the discomfort with the tension between innovation and maintaining service provision levels; "…I will acknowledge is getting back to that professionalism because I think sometimes creativity and thinking outside the box has come at the expense of the core capabilities of what we do and our traditional knowledge of professionalism…"

The result is a feeling among direct service providers of being held back despite wanting to move forward with the change, as these participants articulated; "We are being as innovative as we are allowed"; "It's like you're tethered and your running forward and that rope is stretching but you're not getting far enough. Like we're stuck. Like I'm stuck because I want to forge forward but I can't because I'm being held back."; "…I definitely would like to see something happen where I could be a part of it."

Time / workload.

Organizational change takes time and energy. Time and workload emerged as a significant barrier for the agency's recovery organizational change. The issue emerged at the

direct service provider level; "…I want to learn more and do as much as I can but I don't want to do it at the expense of the time I should be spending with [service recipients]. That's the reason we're here." Time and workload was similarly an issue at the management level as well, as this participant reflected upon past experience, "…And certainly the management team…the constant message of 'If anything is added to my workload – that's the straw that's going to break my back. I cannot take on anything further.'"

Perhaps linked to the issue of time and workload was prioritizing recovery change above other tasks. As this participant noted:

> And you know in all honesty there is so many staff that don't read their emails, don't know what's going on, don't even care to know….You know, and they're like "when is this over because I have stuff I have to do and that's why I didn't read any of those emails…"

Summary.

Analysis of the six contextual sub-themes (history, location, community, innovation, outcome expectations and time / workload) revealed the importance of, 1) teamwork to support creative thinking and increased workload across the organization, 2) a thorough understanding of the history of the organization and the established cultural context, and 3) framing recovery in a manner that was congruent given historical and community contexts. The next major theme that emerged from the data was leadership.

4.2.2 Leadership

The data revealed different implications for informal and formal leadership, and both sub-themes are explored.

Informal leadership

Leadership does not always mean formal leadership. Informal leaders (or recovery champions) are needed too (Anthony & Huckshorn, 2008). There was evidence that the recovery change team provided effective informal leadership that which was largely appreciated by most of the direct service providers. As one direct service provider described:

> And so far what's been most beneficial I think is ….having the recovery change team. Although it was a small group – having a specific group of people who are so knowledgeable and so enthusiastic about it spread throughout the agency. You know, little pockets of this little recovery sunshine all over the place … they're an easily accessible resource…

Conversely, the value of the informal leadership was not fully recognized by those who were not direct service providers, as the following participant described:

> Initially the team was conceptualized as the 'champions' of the process. And very quickly we realized that that was not good. You know if we are going through our own agency of recovery process, and then setting aside a select group of people as being the champions and experts, telling the rest of the agency how to do this, we are not honouring those very basic values that people need to learn and discover and grow together and not be dictated down.

At the time of the interviews for this project, the informal leadership via the recovery change team had been dismantled, though the formal leadership remained.

Formal leadership.

Fortunately those who had an existing relationship with the formal (executive) leadership had a strong sense of trust in leadership. For those who did not have a strong a relationship with

the executive leadership described the desire to build one; "I think we need to be able to be more comfortable and be able to see our directors, our higher ups more on a regular basis."

Once again, the management struggle with reconciling the tensions of innovation (leadership) with maintaining service provision (management), limited their capacity to provide leadership. For example, one manager reflected; "…what happens to the people who can't deliver this, or they THINK they are delivering it but they are not?"

Once again, the direct service providers identified the some members of the management team as barriers to recovery organizational change. As one participated articulated:

> …this was said over and over again, was that this is not – cannot – be a bottom-up change. That it has to be top-down. It's got to come from the management who needs to walk the walk. And can't just expect the [direct service providers] to be doing it if they can't follow the same examples.

Similarly another participant noted, "…having management – a *strong* and supportive management team that understands what recovery is – that are all on board." Further, another participant explained, "…it's aggravating. I see a lot of decisions being made that are not client based decisions – they are operational based decisions."

Summary.

Where management responsibilities were mainly logistical functioning and ensuring service provision, leadership emerged as a means of inspiring innovation and motivation while challenging preconceptions. The data suggested that they agency may be management-heavy whereas strong leadership was needed at this crucial time of organizational change. Attention is now turned to communication.

4.2.3 Communication

Communication can be an important vehicle for leadership; from sharing recovery philosophy to disseminating implementation strategies. The data suggested three communication sub-themes, 1) teaching recovery, 2) strategies for implementation, and 3) consistent messaging.

Teaching recovery.

Recovery organizational change was facilitated by the innovative use of the recovery change team to share recovery philosophy and learning, as this recovery change team participant described:

> Each recovery champion person was designated staff that they have connections to in the organization to have these conversations – these informal fire-side chats; "How's it going? What are your thoughts on recovery? How do you feel this is all going?"

Though there was evidence that some direct service providers appreciated the opportunity to discuss recovery issues with members of the recovery change team, overall this formalized approach was reportedly unsuccessful by a member of the recovery change team.

Strategies for implementation.

Most interviewees, regardless of organizational position commented positively on how they were involved in the development of the recommendations. Conversely, many found email communication confusing or inaccessible because of time, and stated they would prefer verbal or in person check-ins with the formal leadership, as captured by this participant's statement; "Email is so unpersonal. …If we had a 15 minute check in [with formal leadership] once a week with OTN [videoconferencing system]…that would be great."

Consistent messaging.

Providing consistent messaging was a clear barrier to recovery organizational change for the agency. Challenges emerged in both delivering the messages; "And other things like draft materials that we were looking at and making changes to …getting out amongst staff way before intended to…"; and in receiving communication; "And you get mixed messages, like I'm still getting mixed messages."

Though the mechanics of communication was an issue, an underlying inconsistent message was revealed during data analysis that may have rather large implications. The issue was how to engage existing staff members, avoid alienating them from the change efforts, while simultaneously challenging their existing preconceptions. For example, on the one hand, there were messages like this participant made that which resemble treading lightly with people who may resist change; "…we still need – there is still place in our agency no matter how recovery focused you become, there still needs to be a place for the old clinical part of it." Similarly, this message from another participant;

> So active resisters. Or and using recovery respectful language: 'Keepers of Tradition.'…These are the people that have gone through change before and they have seen it go wrongly and badly …They can ensure that you are not throwing the baby out with the bath water.

The hesitancy to step on toes was evident, and yet, there were conflicting, very strong messages calling for the time to change. Take for instance this comment from a participant; "I've heard from supervisors, 'You're either on the train when it leaves the station'…" The train leaving the station was a common analogy that was emerged in all three locations suggesting pervasive and wide-spread use. The existence of such a significantly problematic double

message may create more barriers to the overall recovery organizational change, as it may undermine motivation for critical introspection and authentic change.

Summary.

While there was evidence that clear communication can facilitate idea sharing about recovery philosophy and strategies for implementation, it seemed that *consistent* messaging was also critical. While inconsistent messaging may not have been apparent to the participants, the analysis suggested implied messaging of "you don't really have to change if you don't want to" would be a probable barrier to overall recovery organizational change. The discomfort that factors into inspiring change amongst employees leads into the exploration of the next major theme, challenging preconceptions.

4.2.4 Challenging Preconceptions

To some, challenging the preconceptions that we hold close can be a difficult and uncomfortable endeavour. It is much easier to interpret knowledge in a way that is congruent with existing assumptions. Given that the literature suggests recovery knowledge and practice is different than traditional practice (in particular medical-based practice) the need to challenge preconceptions is far greater. The data revealed three sub-themes, 1) definition, 2) bio-medical model, and 3) peer professionals / stigma.

Definition.

The lack of a consistent definition of recovery has been identified as a significant challenge for organizational change (Clossey & Rowlett, 2008; Davidson, O'Connell, Tondora, Styron & Kangas, 2006; Piat, Sabetti & Bloom, 2010; Thomas & Fraser, 2009). One of the first agency-wide activities the agency engaged in was dedicated to development of the recovery definition. Alongside that activity was the identification of core values to be used as a reference

to guide recovery decision making in practice. The definition established by the agency was "We believe recovery is a unique ongoing journey. It is living a meaningful life to its fullest."

Despite the extraordinary participation of nearly all employees (and others) to develop the definition, coupled with the wide spread circulation of the definition, there was not one single person interviewed who was able to recite the definition. In the end, each interviewee shared their own unique interpretation of the definition. The result was a variety of interpretations. For example, the description offered by this participant reflected common assumptions of the medical model yet the participant did not recognize it as such:

> The mental illness may still be there, but it's that you may be able to handle the symptoms or be aware of your own coping skills style and how to manage the illness whether it would be by medication or meditation or mindfulness, something. The illness will always be there unlike in the medical model, that you are trying to cure."

Another participant defined recovery in this manner; "what is recovery? I don't think you need to know. We don't define it."

This participant identified how the lack of consistency was creating barriers for the overall recovery organizational change:

> I also think that any issue in applying the recovery model is more a lack of clarity between each worker…we are both really interested in encouraged by the recovery process, but we have different [meaning] for each of us, so as a team if each person on the team has a different idea of what recovery looks like in a tangible way then you have that conflict between colleagues…lack of consensus.

Further this participant said, "…we are not clear about what recovery is, how the heck do you put something into practice if you're not even sure how to define it?"

It would follow, then that the lack of a firm definition opens the door for employees to frame recovery in a manner that allows their preconceptions to remain intact. For example, this participant stated:

> You may have heard this expression but we literally heard it here, "but we do recovery" … isn't a really good understanding of the whole concept and in fact was dismissive. It allowed us to say we were doing recovery without actually [changing]…do we have an understanding of what that actually means and what that looks like and without having a genuine respect for that philosophy.

Given the dominance of the medical model ideology in mental health practice, it is important to become fully aware of its influence in thinking.

Bio-Medical model.

A common bio-medical model assumption of mental health prognosis is that outcomes will be fairly negative (Ridgway, 2001) unless there is proper diagnosis and medical treatment (Clossey, Mehnert & Silva, 2011). Traditional mental health services at the agency have been similarly bio-medical model oriented as this participant reflected; "We have a long history of being deficit-focused."

There was an acknowledgement within the agency that consideration beyond the bio-medical model was needed, as this participant described:

> …our usual way of doing business is a false promise. It's not working in the way we told people it would. So the idea that we tell people that if you take this medication and come in for this therapy you'll be all better. It doesn't work and life isn't that simple.

Yet there were ample examples of how the bio-medical model continued to dominate practice assumptions at the agency. These participants described their discomfort with a service recipient choosing to discontinue prescribed medication treatment:

> But I think also just monitoring frequently if somebody is – not that not taking your pills suggests you are decompensating – but if someone is making a choice that you feel may ultimately will lead down a dangerous road eventually, monitoring them every step of the way…
>
> …we can ask open-ended questions…. "Why do you feel this is for the best? How can your doctor help with those kinds of concerns? Do you feel you need a medication adjustment? Do you have difficulty with the side effects?"

Similarly there was evidence for highly medicalized interventions, as described by this participant:

> …most of the people that come through our doors and a lot of what we do in terms of direct service is talking to people about medication or people are on medication….that has a big impact on what we have done and do.

Further, medical assessments were prioritized for service recipients' access to some services, like a walking group. Service recipients who wanted to take part in a walking group for wellness needed to have a PAR-Q completed (a scale of physical health that a medical doctor needs to fill out saying a person is medically cleared to participate in physical activity).

There was also an assumption that clinical supervision should come from psychiatrists (experts within the bio-medical field) as this participant shared:

…when we sit down with [name of psychiatrist] and we listen to a clinical presentation on a client…then he draws us to a conclusion and we…figure out a diagnosis of this person….I think "That's clinical supervision. That's growth."

The bio-medical was also the dominant paradigm that was used in educating volunteers as this participant explained; "…mental health 101 training on symptoms and medications and different things they should be alerted to and they see anything that can be concerning they report it to us first."

The data also revealed a theme related to peer professionals.

Peer professionals.

Employing peer professionals is a hallmark of recovery services and this was not lost on the board and executive at the agency. There was an expressed commitment to have 50% of the employees as people with lived experience. Indeed the shift has begun with existing staff coming forward to disclose their lived experience as this participant described, "…it's a handful and growing that have felt comfortable enough to come forward with some of their backgrounds and acknowledge that they have experience and at a time suffered from mental health disorders."

The complexity arising from introducing peer professionals can be a stand-alone study. While for the most part people were enthusiastic about the introduction of more paid peer professionals into the work environment, there was evidence of fear expressed throughout the organization. These different participants described the fear for role that they had witnessed:

> There is a fear…that we were going to dismiss professionalism, dismiss a lot of the skill sets that people have and go to a more informal only listening to a person's story, only following their lead, being very peer centred misunderstanding of recovery.

> There are new jobs, there are job titles I think people fear for their jobs or fear there is like a mental health worker the equivalent of a recovery coach? Not quite, so where do I fit?

Similarly there was evidence of fear of job loss, as articulated by these participants, "…will there be less jobs required to fulfill this model when it's less directive and our clients are doing more for themselves? Will I be needed as much?"; "And there was a fair amount of fear I guess from staff before the recommendations went forward … would be losing their jobs."

There was also evidence of a lack of recognition for the contribution that peer professionals could make in the organization as described by this participant:

> …you can't reduce the skilled staff, the education, the ssw [social service worker], social worker, nurses, you can't reduce that capacity to service for the reason of bringing in peers….I was at least reassured that it wasn't going to be at the risk of reducing the quality of what we were doing for these people.

Further there was also concern for how human resources issues will be tailored to accommodate what was assumed to be more sick time, as this participant noted, "I'm excited about it all, but you know the fact that we don't have a definition yet of Peer and what that means….what is that going to look like when we have people on sick leave?" As questions emerge for how to accommodate peer professionals, direct service providers are recognizing the lack of consistency as this participant described, "And there are people on staff that are - that have lived experience. And they are treated differently…Some are embraced and accommodated and some aren't. …the agency is recovery focused, but not for everyone."

Summary.

Though there was evidence that supported the important exploration of recovery philosophy, the analysis revealed that the dominance of medical model ideology was on the periphery which may inhibit a dramatic recovery organizational change. Efforts related to practice emerged and are discussed next.

4.2.5 Practice

"But we need to get better at applying those learnings." - Participant

Translating recovery knowledge into practice can be a challenge (Uppal, Oades, Crowe & Dean, 2010). The data indicated three sub-themes, 1) training, 2) supervision, and 3) language.

Training.

Translating recovery philosophy into practice is not an easy task (Farkas, Gagne, Anthony & Chamberlin, 2005). The data suggested that the agency had provided all employees with reading materials and regular semi-structured discussion opportunities that had originated from one of the sites visited from the United States called "Keeping Recovery Skills Alive." The quantity of information was deemed helpful as this participant noted, "…you come into an environment where it's being implemented [and] you get a lot more information and a lot more time to think about it and discuss it."

On the other hand, the pro-offered information relied heavily on self-directed learning, which this participant believed was a barrier to learning, "People aren't going to read it. They're not. Maybe a few people, a handful of people will - but people are busy or they are not interested or there's other priorities."

Given the pre-established evidence that people were framing recovery in a manner that fit closer with their own preconceptions, self-directed learning may have been particularly

problematic as this participant described, "So we are just kind of on our own thinking that this is recovery or I read this and I relate to this as recovery and somebody else read something totally different and somebody else didn't read anything at all…"

Though the semi-structured "recovery skills alive" discussion series was offered, attendance was not mandatory as this participant described, "We are not forcing people into the conversation, but what we do have is regular ongoing of what we have learned. So "keeping recovery alive" skill sessions on a weekly basis that people are invited to attend. You do have people that are not interested, and aren't attending." It is possible that by not setting the clear expectation for engaging in training, the inconsistent message previously described was reinforced.

Training need not only take the form of formal training. Another way that members of the organization can hone their recovery skills is by supervision.

Supervision.

There was evidence of pockets of rewarding, recovery-focused clinical supervision that helped shape recovery beliefs and practice as the following participants noted,

> "[I'm asked]…'How do you demonstrate recovery in your day to day work?'"….it's been a slow process, especially initially. We had some backlash…from our more challenging people… 'You think we're stupid? You think we don't know what recovery is? We've been doing recovery for years' … Now some of those people as time went on were able to come back and say 'Wow, you know there is a lot more to it than what we thought.'"
>
> "I really like that with [name of psychiatrist] because it makes such a difference … [he says to people] 'It sounds like you really have a lot on your plate right now'…You could

just see the switch when he would use positive language. And he didn't like labels and he would much more refer to the ability to cope."

Evidence indicated that quality clinical supervision was more of an anomaly at the agency. The majority of participants reported a lack of supervision, "There's none [clinical supervision]… There is the daily recipient workload! [referring to the daily statistical tracking work time];" and, "Well it's every 6 weeks you meet with your manager and you go through your caseload and you decide what you are doing with each….Are the OCANs done and all of that administrative crap." and "I don't do regularly scheduled check-ins and I am supposed to. It's more of an as needed basis. So some people;" and finally, "We are supposed to meet once every month or 6 weeks to, well we were going to do case reviews and stuff. But it's never happened."

There was evidence that supported the shift in recovery practice that emerged from the data. A handful of participants spoke of the recent organization-wide recovery language activity which yielded a new organizational glossary.

Language.

The importance of undertaking the language activity was eloquently expressed by this participant, "The way you speak about something determines influences your attitude, influences your behaviour. If we can change the language we are probably changing a lot of things."

The agency recovery change activity encouraged participants to choose a team (and all were encouraged to include members both from outside their geographic location and people with lived experience). Teams were challenged to suggest alternatives to commonly used terms found in practice. An example was the term "direct service provider" in place of "front-line staff." The language alternatives were judged by a panel of people with lived experience based

on the resonance of the alternative with recovery-values. This participant felt the result was quite positive, "…the piece that I really feel that greased the wheel was when we embraced the language piece. Shifting that really – I can see the momentum changing."

Summary.

As the agency explored recovery philosophy a plethora of information was available for self-directed learning, that not all employees were prioritizing to take in. In addition, the agency offered ongoing discussion sessions that were not mandatory to attend. Given that supervision was inconsistent across the organization, efforts to build recovery practice may be fully supported. On the other hand, there was evidence that the recovery language activity was highly beneficial and had promise to influencing recovery practice.

4.3 Summary of Findings

Recovery organizational change at the agency had a rather organic beginning with people exploring recovery at different times, through a variety of means. Momentum for the overall project grew with the executive decision to create the recovery change team. The recovery change team was comprised of representatives from management, direct service, clients, and board members who were formally tasked to 1) gather recovery organizational knowledge, and 2) develop recommendations for recovery organizational change to the executive and administration of the agency. A fortunate spin-off of the recovery change team was the informal leadership provided that was found to be particularly helpful amongst the direct service providers.

Overall the theoretical shift has been somewhat smooth, and with particular attention to enhanced innovation, leadership and consistent communication and messaging, the change will

continue. The data revealed a much broader challenge; that of challenging preconceptions to fully explore authentic recovery practice.

CHAPTER 5:

DISCUSSION

The purpose of this research was twofold; 1) to outline the steps taken by change agents and 2) understand the experience, including successes and challenges, of organizational change at the agency. The corresponding research question was, "How did a community mental health organization change to adopt recovery philosophy and practice?"

While some authors regard organizational culture as adoption of salient recovery philosophies (Clossey, Mehnert & Silva, 2011; Piat, Sabetti & Bloom, 2010); others identify the need for a shift in specific internal systems and practices to develop a new organizational culture (Whitley, Gingerich, Lutz & Mueser, 2009). Some writers suggest that a shift of organizational culture is the blending of both (Clossey & Rowlett, 2008; Perkins & Slade, 2012). The data suggested the agency engaged in the later. Though recovery organizational change may require re-conceptualization of logistical mechanics (for example the restructuring of teams), close examination of that aspect was beyond the scope of this project.

5.1 Steps taken by change agents

5.1.1 Recovery Organizational Change Theory

To explore the first research objective of this study - outline the steps taken by change agents; the data is juxtaposed against both mental health and business management organizational change literature. Supporting literature on mental health recovery organizational change was sparse. Only two articles were related to similar recovery journeys like that of the agency; Shephard, Boardman and Slade (2008) and Piat, Sabetti and Bloom (2010).

Shephard, Boardman and Slade (2008) suggested organizations consider the following items in their change process: 1) revision of the mission statement; 2) commitment to involving people with lived experience in all levels of the organization; 3) conscious shift from "therapeutic" model to an "educational" one; 4) hiring of peer professionals; 5) commitment to growth to build upon the core values and targets. The data suggested the agency made movement in the commitment to involving people with lived experience in all levels of the organization (#2); a conscious shift from "therapeutic" to "educational" models (#3) and a commitment to build on the core values and targets (#5). The data suggested there were many other factors that either facilitated or inhibited organizational change beyond those items identified by Shephard, Boardman and Slade (2008). Further, the Shephard, Boardman and Slade (2008) model failed to capture the challenges associated with challenging preconceptions.

Piat, Sabetti and Bloom (2010) introduced six implementation needs for organizations to consider in their organizational recovery journey: 1) develop an agreed upon definition of recovery; 2) community development to reduce stigma; 3) hold direct service providers accountable for recovery-practice implementation; 4) develop new standards for professionalism; 5) get people with lived experience involved in organization as a whole; 6) create new standards

and outcome measures to support the change. The six needs moved closer to accurately capture the themes that emerged from the agency data.

Develop an agreed upon definition of recovery.

It was well documented in the literature that the lack of consistent recovery definition created a barrier for organizational change (Clossey & Rowlett, 2008; Davidson, O'Connell, Tondora, Styron & Kangas, 2006; Piat, Sabetti & Bloom, 2010; Thomas & Fraser, 2009). As reflected in the data, the agency engaged in a lengthy process to develop their definition of recovery and related values to guide all members of the organization. Though the agency definition was complete, there was evidence that practically all employees' personal definitions did not fully align with the new definition, and the influence of the dominant bio-medical model paradigm remained unquestioned. The researcher therefore suggests that the establishment of a recovery definition in itself is not enough to promote change. Instead, the development of a new definition may benefit from a detailed analysis of the power of dominant ideologies.

Engage in community development to reduce stigma.

If recovery oriented services consider the impact of social stigma and oppression (Clossy, Mehert & Silva, 2011; Piat, Sabetti & Bloom, 2010; Ridgway, 2001) as opposed to limiting the analysis to the internal functioning of physical chemicals, it would follow that efforts must be directed toward creating recovery communities. To aid in fully understanding this concept of community development, one may consider the parallels with the deinstitutionalization of people with developmental disabilities.

Cayley and Sinclair (1994) produced a radio documentary for the Canadian Broadcasting Corporation entitled "Beyond Institutions." Lister Sinclair interviewed David Cayley about deinstitutionalization of people with intellectual disabilities. Cayley demonstrated how

institutionalization had removed people with intellectual disabilities from the social fabric of communities to such an extent that when people were being placed in community group homes, it was a shock to the community to have them in their midst (Cayley & Sinclair, 1994). Cayley identified how efforts to educate the community to embrace people with intellectual disabilities were paramount.

Though there was evidence that the agency made efforts to build recovery communities, as evidenced by the partnerships from the photovoice project, at this juncture it was evident that change efforts were predominantly inward looking. Where participants reflected on community service providers, they noted how the agency's services were evolving whereas others were not, though the analysis did not extend to considering the power dynamics that may be expressed in this dichotomy. The researcher would therefore encourage the agency to engage peer professionals in the community development work as the existing literature would promote such an approach (Corrigan, Larson, Sells, Niessen & Watson, 2007).

Hold direct service providers accountable for practice implementation.

The data suggested there was hesitation to hold direct service providers accountable for practice implementation at the agency. Instead it was believed that employees' practice ought to grow with the new knowledge. While there may be some benefit to an organic growth of knowledge, that assumption may minimize the existing power disparity between service providers and service users in that, 1) service providers have a responsibility to provide the best possible service for the service users; 2) there is a long history of oppression (that is still ongoing) in which service provision is enmeshed.

In addition, there was evidence that a natural organic evolution approach my inadvertently slow organizational change. An example was the albeit respectful title, "keeper of

tradition" for people who are resistant to challenging their preconceptions may send the message that practitioners don't have to change if they don't want to and would not fulfill the requirement set out by Piat, Sabetti and Bloom (2010).

Develop new standards of professionalism.

There was minimal evidence in the data for the development of new professional standards. Specific to the agency data set was the intersection of new standards of professionalism and the hire of peer professionals. The data revealed assumptions that, 1) peer professionals were unable to deliver quality professional services, and 2) employing peer professionals would negatively impact traditional service provision. These two issues point to the need to develop new standards of professionalism to challenge the dominance of traditional values and underlying stigma. Would the same issues emerge if the organization made the commitment to employ a workforce comprised of 50% clinical psychologists?

As an aside the researcher cautions against potentially watering-down the peer professional designation by underplaying the experience of gross social oppression. The data revealed that at the agency already employed employees were coming forth and disclosing their own history of mental illness, thereby taking on the designation of peer professional. While the shift is worthwhile and important, peer professionals ought to also have had experiences not only of symptomatology, but the social oppression, like lengthy hospitalization, poverty, discrimination or trauma when working with service recipients with those experiences.

Involve people with lived experience in organization as a whole.

The change activities thus far at the agency consciously included people with lived experience wherever possible. People with lived experience joined the recovery change team's lengthy quest for knowledge, had input into the development of the recommendations, and were

judges of the recovery language project. There was also the commitment by the administration to have 50% of the staff consist of people with lived experience which is significant. The researcher wonders what impact having a peer professional as a provider of clinical supervision (as opposed to a psychiatrist) may impact.

Create new standards and outcome measures to support the change.

Though participants from all employment levels felt traditional outcome measures were inadequate, they were inconsistent in their desire to develop new ones (where some saw the value in creating new outcome measures and others did not).

Summary.

The six implementation needs set forth by Piat, Sabetti and Bloom (2010) helped to broaden the lens to include contextual factors and issues of responsibility and accountability that would be important to consider in recovery organizational change. The needs came short, though, from describing the many layers of power dynamics that impact organizational change.

There was a clear gap in the mental health literature to support large scale recovery organizational change. Though Shephard, Boardman and Slade (2008) and Piat, Sabetti and Bloom (2010) did offer important issues to consider in adopting recovery philosophy, the mechanics of how to influence large scale practice and operations were still gaps. To help shed light on large scale organizational change, one may look to literature outside of mental health discourse.

5.1.2 Business Management Organizational Change Theory

Although the recovery-based organizational change theory helps to frame the experiences of the agency, that research area was not as well established as comparative literature in the world of business management. Though there were many organizational change theories to

choose from within the business management literature, the models offered by Peirson, Boydell, Ferguson and Ferris (2011) and Kotter and Cohen (2002) were selected based on their suitability for mental health organizational change.

Peirson, Boydell, Ferguson and Ferris (2011) developed the Ecological Theory for organizational change. Change in that model was a fluid process that had four over-lapping phases; 1) interdependence; 2) cycling of resources; 3) adaptation; 4) succession. One of the basic prerequisites for Ecological organizational change was a thorough understanding of what change was required. Though the agency spent time and resources to developing the recommendations and definition of recovery, there was evidence that they did not address the power of the dominant bio-medical discourse, which may be a missing link.

According to Peirson, Boydell, Ferguson and Ferris (2011), the outcome may not be a fully articulated end state and different parts of the system will evolve organically and at different paces than other parts of the system. That perspective bears a strong resemblance to the organic nature of knowledge and practice development suggested by some participants.

While this model holds appeal in particular with recovery values and makes sense when there was such a lack of literature to support recovery organizational change, the lack of clarity for guiding change can inhibit the direct applicability of this theory. For example there was evidence that suggested how in the absence of direct communication, supervision and training, recovery values can be interpreted in a variety of ways, which can ultimately hold an organization back.

Kotter and Cohen (2002) developed a widely-tested model of organizational change. The model sets forth eight clear steps for change agents to follow; 1) increase urgency; 2) build guiding team; 3) get the vision right; 4) communicate for buy-in; 5) empower change; 6) create

short-term wins; 7) don't let up; 8) make change stick. The efforts described by the agency will be compared to the first four steps outlined by Kotter and Cohen's (2002) model since the agency has recently embarked on the change process and has not progressed past the first four steps.

Step one: Increase urgency.

Some researchers identified using training as a means to ignite practitioner's interest in changing, 1) practice (Deane, Crowe, King, Kavanagh & Oades, 2006), 2) the organization (Becker, Torrey, Toscano, Wyzik & Fox, 1998; Whitley, Gingerich, Lutz & Mueser, 2009) and, 3) the culture (Peebles, Mabe, Fenley, Buckley, Bruce, Narasimhan, Frinks & Williams, 2009; Thomas & Fraser, 2009). The difference though is that Kotter and Cohen (2002) strongly suggest that the key to creating an increased sense of urgency was not to appeal solely to the cognitive reasoning for the need for change, but to frame the change in a manner that connects to an individual's emotions. It makes sense then that cerebral arguments for recovery offered by way of training would not achieve the urgency required for deep preconception challenges. The agency data set did not reveal activities to draw upon the emotional sensibilities of employees.

Step two: Build the guiding team.

The recovery change team was an excellent example of a guiding team of recovery change champions and was unique to the agency as compared to the mental health literature. As revealed in the agency data, the recovery change team served as effective informal leadership and would fulfill the requirements of Kotter and Cohen's (2002) second step.

Further, Kotter and Cohen (2002) suggested that members of the guiding team should have decision-making authority, and one of the recovery change leads was a member of the management team.

Step three: Get the vision right.

According to Kotter and Cohen (2002), the time spent by the agency to create the clear recommendations, define recovery and change language would facilitate change. The researcher would add that strategies which clearly articulate how recovery practice differs from traditional practice may be helpful.

Step four: Communicate for buy-in.

Though the recovery definition and values were widely circulated and available to all members of the organization, there was evidence it had not been adequately internalized, indicating the need for further buy-in. The question of the usefulness of the term "keepers of tradition" represents the unique challenge of clear communication for buy-in. Though the title "keepers of tradition" was created as an attempt to engage resisters, it was questionable if the implied double message would create more barriers than it prevented. Combined with the non-mandatory training, the agency may encounter barriers to buy-in.

Step five: Empower change.

The literature in general clearly indicated that organizational change is not immediate, is often resisted and takes time, therefore many hands are needed to implement change. Although many participants expressed interest in changing, many direct service providers in particular were feeling held back from exploring recovery in their practice. Kotter and Cohen (2002) may suggest that the agency work to foster change efforts in a variety of ways, to keep the momentum going.

Summary.

This study's first research objective was to outline the steps taken by change agents at the agency. Through an analysis of the data in comparison with both mental health and business

management literature, it was evident that there were activities that both facilitated and hindered the overall recovery organizational change. Moving into the second research objective of understanding the experience including facilitators and challenges of organizational change, the researcher conducted secondary and tertiary analyses (as per Tutty, Rothery & Grinnell, 1996). These analyses are presented below, accompanied by an exploration of relevant theory.

5.2 Understanding the experiences, facilitators and barriers

In this section the themes identified in the data are compared against the existing literature (secondary analysis), followed by an examination of the interaction between themes in the tertiary analysis.

5.2.1 Secondary analysis

The secondary analysis of data consisted of a comparison of themes with the existing literature. Building on the findings Table 3 (Summary of Findings), Table 4 (Comparison of themes with existing literature - below) provides a summary of how the themes compare with the literature.

Table 4: Comparison of themes with existing literature

Theme	Facilitators from Interviews	Barriers from Interviews	Literature
Contextual Factors			
Organizational history	Returning to roots	Dominance of bio-medical model	Impact of unionized environments (Drake & Latimer, 2012).
Location	Efforts to unify	Lack of teamwork	Necessity of strong teamwork for critical reflection (Thomas & Fraser, 2009).
Community	Responsive community	Creating recovery community	Need to create a welcoming community (Cayley & Sinclair, 1994).
Outcome expectations	History of inadequate measurements		New standards for practice aids success (Piat, Sabetti and Bloom, 2010; Smith-Merry, Freeman & Sturdy, 2011).
Innovation	Belief there is passion and innovation	Management balancing tension between maintaining service provision and	Importance of creating a culture of innovation (Clossey & Rowlett, 2008; Shepherd, Boardman &

		innovation	Slade, 2008).
Time/workload		Priority setting	Change takes time
Leadership			Leadership a key factor that supported implementation of recovery (Anthony & Huckshorn, 2008).
Informal leadership	Recovery change team	Concern about having champions	
Formal leadership	Trust where there is a relationship	Desire for more relationship	
		Management heavy and poverty of leadership	
Communication			
Teaching recovery	Recovery change team	Value of recovery change team uncertain	Clear and saturated communication of new values is crucial (Deane, Crowe, King, Kavanagh & Oades, 2006; Kotter & Cohen, 2002).
Strategies for implementation	Recovery change team	Email communication confusing	
Consistent messaging	Circulation of drafts	Double messages	Communication critical for both new culture (Clossey & Rowlett, 2008) and combating resistance (Callaly & Ayra, 2005).
Challenging Preconceptions			
Recovery definition	Creation of organizational definition	Multiple interpretations and uses	Firm definition needed (Davidson, O'Connell, Tondora, Styron & Kangas, 2006).
Bio-Medical Model	Recognition of need to change	Many examples of continued dominance	Challenging for workers who identify with bio-medical model (Callaly & Ayra, 2005; Clossey, Mehnert & Silva, 2011).
Peer Professionals	Commitment to 50% staff of people with lived experience	Concern about professionalism and job loss	
Practice			
Training	Lots of information available	Priority setting	Only 37% transferred new knowledge into practice (Uppal, Oades, Crowe & Dean, 2010).
		Not mandatory	Genuine belief among workers that they were already delivering recovery services (Clossey & Rowlett, 2008).
Supervision	Pockets	Not available to everyone	Transfer of knowledge requires clear guidelines expectations and ongoing, quality supervision (Becker, Torrey, Toscano, Wyzik & Fox, 1998). Trust needed for supervision (Raza & Standing, 2011).
		Assumption that needs to be delivered by psychiatry	
Language	Overall positive		Culture and values reflected in language (Clossey, Mehnert & Silva, 2011).

As Table 4 illustrates, minimal themes were supported by the literature, more were not, and in some cases, the data revealed themes unique to this particular research with no corresponding representation in the literature.

Only three themes were directly supported by the literature, 1) pessimism, 2) leadership and 3) language. The data revealed that some members of the agency were pessimistic of change, seeing recovery as a passing fad, and one of the litanies of good ideas that were initiated by the organization before that never reached fruition. Similarly, both Callaly and Ayra (2005) and Ridgway (2001) noted how some participants saw recovery as a passing fad.

The data revealed the need for more formal leadership at the agency, which was supported by the literature by many writers (Anthony & Huckshorn, 2008; Becker, Torrey, Toscano, Wyzik & Fox, 1998; Callaly & Ayra, 2005; Clossey & Rowlett, 2008; Oades, Crowe & Nguyen, 2009; Piat, Sabetti & Bloom, 2010; Raza & Standing, 2011).

The language project undertaken by the agency was seen as a resounding success by many participants and was reportedly instrumental in shifting the culture and expression of values of the organization. The research of Clossey, Mehnert and Silva (2011) supported that finding, stating that culture was created by language that which reflected the new values of the organization.

Conversely, some of the themes from the data were unsupported by the literature. In particular, 1) informal leadership, 2) communication, and 3) practice standards. Despite the appreciation expressed by direct service providers for the informal leadership provided by the recovery change team, there was some concern expressed about having recovery change champions. Anthony and Huckshorn (2008) identified informal leadership as a key for recovery change.

Closely linked to the leadership discussion was communication. There was evidence of inconsistent messaging at the agency related to challenging preconceptions and changing practice. Directive messaging (for example "the recovery train is leaving the station – are you on?") were presented alongside with placating messaging (for example labelling resisters as "keepers of tradition"). The literature called for clear, effective and saturated communication of new values whether to alter organizational culture (Clossey & Rowlett, 2008) or in combating resistance (Callaly & Ayra, 2005), suggesting the approach used by the agency may not be ideal.

Recovery has potential to be something quite different from traditional practice and will require serious re-evaluation and reflection of preconceptions and the development of new practice standards. Otherwise, recovery can be swallowed up by the dominant paradigm. The establishment of new practice standards and service outcomes offers a vehicle for recovery values to be translated into practice (Piat, Sabetti & Bloom, 2010; Smith-Merry, Freeman & Sturdy, 2011). Conversely, the data was ambivalent about the commitment to developing new standards for practice. In fact, the data revealed how nearly all participants defined recovery in their own way as opposed to the organization-wide definition which may be contributing to conflicting practice decisions and ultimately limiting innovation. For example, as people interpret recovery philosophy in a manner that is congruent with their existing preconceptions the nuances of how recovery differs from traditional practice may be lost. Hence practitioners believe that they are already consistent with recovery practice and ultimately the expression of recovery in the organization as a whole is watered-down. If that same practitioner is a manager, and hence gatekeeper to permission for innovative projects, the pathway for innovation may become blocked and frustration can brew. In organizations that held a firm recovery definition, change was more successful (Davidson, O'Connell, Tondora, Styron & Kangas, 2006).

The literature was incongruent with some of the thoughts on informal leadership and communication strategies that emerged from the data set. Similarly, the literature may help guide the agency in planning the next stages of their recovery journey in regards to practice standards and internalization of the recovery definition.

Perhaps the most significant contribution the agency may offer to the recovery organizational change research community was the implementation of the recovery change team. Nowhere in the mental health literature does the development of a specific team to be imbedded within all levels of the organization to seep recovery knowledge and values from within was considered. Given the appreciation expressed by the direct service providers coupled with the support from the literature for leadership, the recovery change team offered a significant contribution to the body of knowledge and was unique to the agency.

Secondly, the multifaceted and complex issues related to employment of peer professionals were evident in the data. Being that this critical issue was beyond the scope of this study, and really warrants specific investigation to untangle the threads, the researcher was only marginally aware of literature that touched on this topic.

5.2.2 Tertiary Analysis

The themes identified from the data in the primary analysis were not mutually exclusive, isolated occurrences that had no relationship with each other. By creating a matrix, the tertiary analysis of themes revealed three trends; 1) the high potential that supervision, leadership, training and recovery definition will have for future recovery change, 2) the high potential that recovery supervision may have for facilitating change and, 3) the significant barrier that continued adherence to a sole bio-medical orientation, will pose to the recovery organizational change (see Table 5: Thematic Relationship Matrix).

Table 5: Thematic Relationship Matrix

	History	External Factors	Innovation	Leader-ship	Communi-cation	Recovery definition	Bio-Medical model	Peers	Training	Super-vision
History										
External factors	~									
Innovation		~								
Leadership	-	+	- (+)							
Communic-ation	-	-	~	-						
Recovery definition		+	+	+	~					
Bio-Medical model	-	-	-	-		-(+)				
Peers	-	-	+	+		+	-			
Training	~	~	- (+)	+	+	+	-(+)	+		
Supervision	-		~ (+)	~ (+)	(+)	(+)	(+)		(+)	

Intersection will be a barrier to recovery organizational change
\+ Intersection will be a facilitator to recovery organizational change
No strong intersection
~ Intersection is ambiguous at present
( ) Possibility for future

At each intersection in the matrix, there are cues to signify the current relationship in the data. For example, a "-" cue indicates a barrier to recovery organizational change at the time of analysis; a "+" indicates a facilitator; a "~" indicates an ambiguous relationship, and finally where there is no cue indicates the lack of a significant intersection. Cues that are in parentheses indicate the researcher's projection for the future.

Of significance from the matrix, the effort that the agency put into developing the recovery definition has had a positive pay off as that exercise had reinforced the external factors, innovation, leadership, peers and training themes. Framing recovery in a manner that appealed to external funders; the innovative way in which the organization embarked on the recovery definition project (challenging preconceptions on the way), and the intensive training for the informal recovery change team leadership had positive ripple effects throughout the organization. The recovery definition project also has potential in exploring bio-medical

assumptions and supervision. As more people explore and embrace recovery values and perspectives, the relationship with the medical model will shift to allow space for these new paradigms that may be reinforced through recovery-based clinical supervision.

Secondly, the matrix revealed how currently, clinical supervision was not supporting recovery organizational change as well as it could. At present, clinical supervision was weak at best however concerted effort in this domain may impact future innovation, leadership, communication, recovery definition, bio-medical assumptions and training. For instance, should strong recovery clinical supervision be implemented, training through critical reflection upon practice (and bio-medical assumptions) may reinforce recovery definitions and related communication. The poverty of formal leadership would be addressed and innovation may be better supported and openly fostered. An important factor to consider about clinical supervision was the preconception that supervision ought to come from psychiatry (and therefore medical model paradigm). The researcher suggests the agency consider what a difference offering clinical supervision from a recovery paradigm may present. For example, what would it look like if clinical supervision were offered by peer professionals? Considerations such as that may propel the organization toward recovery better than unexamined preconceptions.

Finally, the matrix revealed the potential barrier that continued adherence to a solely bio-medical approach will have to an overall recovery organizational change. For example the agency's external environment and historical roots have been in bio-medical model dominated discourse. Should it continue un-examined, innovative efforts to look beyond that model may be inaccurately scrutinized. The data suggested that the formal leadership (management and executive) value medical model assumptions (and indeed, those participants had been with the

agency for much longer, thereby having had a strong rooting in the bio-medical model heritage of the organization).

Two themes were extracted from the findings and discussion for critical analysis. These two themes helped highlight relevant theoretical issues that contribute to the shift to recovery philosophy for community mental health organizations. The selection of themes was guided by the theoretical influences of the researcher (social constructionist). The themes extracted were: community support and bio-medical model.

Although there were pockets of support within the communities within which the agency is imbedded, some theories suggest that larger societal change is needed to fully realize recovery goals. Recovery represents a shift in values, social activism, and recognition of sociocultural features of mental illness. Social stigma against people with lived experience manifests in many ways in contemporary society, including: barriers to adequate housing, discrimination when seeking employment, limitations to participate in education, social avoidance and limited opportunity to make friends and restricted social service options. Link and Phelan (2001) indicated that stigma resulted from the expression of social, economic and political power disparity. Thus stigma combines segregation with power of a dominant over a subordinate. The result was oppression. According to Borg and Davidson (2008), conceptualizing recovery as a social process appeared to be a relatively new dimension of research focus. That was despite the historical success of Phillipe Pinel, William Tuke and Franco Basaglia. Recovery as a social process was rooted in the belief that recovery was as much (if not more) a socially based experience than a medical one (Piat Sabetti & Bloom, 2010; Shepherd, Boardman & Slade, 2008). Socially, mental illness remains a highly stigmatized phenomenon wrought with

economic, political and social oppression. Recovery as a social process recognized the need to reconcile both internalized and external oppression (Clossey & Rowlett, 2008; Ridgway, 2001).

According to Onken, Craig, Ridgway, Ralph and Cook (2007) recovery has its roots in the survivor self-help movement of the 1930s. As the movement evolved the rallying statement, "Nothing about us without us" emerged to underscore client choice in both decision making and treatment (Clossey & Rowlett, 2008). It has been documented that the stigma associated with the experience of what is medically termed "schizophrenia" is far worse than the symptoms themselves (Corrigan, Larson, Sells, Niessen & Watson, 2007; Rockwell, 2011). Social stigma against people with lived experience manifests in many ways in contemporary society including: barriers to adequate housing, discrimination when seeking employment, limitations to participate in education, social avoidance and limited opportunity to make friends and restricted social service options. Similar to deinstitutionalization of people with developmental disabilities, efforts to reduce oppressive stigma against people with mental health experiences should be included in recovery practice (Clossy, Mehert & Silva, 2011; Piat, Sabetti & Bloom, 2010; Ridgway, 2001).

Should the issue of social stigma, oppression and marginalization of people with lived experiences be challenged, as identified as a need amongst leading recovery researchers and advocates, a progressive approach to social work must be included. This is especially relevant to mental health institutions given the powerful legacy of oppression and abuse toward its clientele.

CHAPTER 6:

CONCLUSION

The full experience of mental illness cannot be described in isolation from the context in which one lives, yet the internal physical manifestation of symptoms has been the focus of treatment in western cultures. The social contextual influences remain hidden, even though it has been documented that the social, political and economic oppression (or "stigma") of people with serious mental illnesses like schizophrenia, can be far worse than the symptoms themselves (Corrigan, Larson, Sells, Niessen & Watson, 2007; Rockwell, 2011). Given this perspective, it is clear that public systems intended to support people with mental illness ought to address their clients' social, political and economic realities as well as symptoms of illness. The "recovery" paradigm has emerged as best-practice philosophy for mental health practice and represents a significant departure from the bio-medical model.

Changing an organizations' fundamental philosophical orientation is no small feat. As Thomas and Fraser (2009) so eloquently stated, "[I]t is typically much easier to embrace philosophy than to put it into practice" (Thomas & Fraser, 2009, p. 154).

Clearly organizational change of this capacity is a colossal undertaking of which guidance is essential (Clossey & Rowlett, 2008). Yet research into recovery-specific

organizational change is sparse. The purpose of this study was to explore 1) to outline the steps taken by change agents within an organization undertaking recovery organizational change and 2) understand the experience, including successes and challenges. The corresponding research question was, "How did a community mental health organization change to adopt recovery philosophy and practice?"

The agency was selected for this case-study based on their dedicated efforts to recovery organizational change. It was anticipated that this research will add to the general knowledge base for large-scale recovery organizational change while providing important theoretical knowledge for other change agents. In an effort to robustly describe the multiple perspectives (Creswell, 2007, p. 126) of organizational change for the employees at the agency, maximum variation as a sampling technique was employed. The maximum variation framework targeted four subsets of employees (recovery change team, management team, executive administration team, direct service providers) and three geographic locations. In the end six individual interviews and four focus groups were conducted, for a total of seventeen participants.

Audio interviews were transcribed into written format and underwent two types of data analysis following guidelines set forth by Tutty, Rothery and Grinnell (1996). In the end, five broad categories emerged from the data (contextual factors, leadership, communication, challenging preconceptions and practice). Each of these categories were broken down to smaller sub categories that were found to influence recovery organizational change. Secondary analysis revealed how each of those five categories and multiple sub-categories were compared to the existing literature. Where some sub-categories were supported, and others were un-supported, there were some categories that were unique to the agency, thereby offering additional knowledge to recovery organizational change. The analysis continued to a tertiary level which

examined the interconnected relationship between relevant sub-categories. Tertiary analysis revealed how improvements in clinical supervision and leadership may lend favourably to further recovery organizational change. On the other hand, the tertiary analysis brought to light the importance of a critical examination of underlying dominant of bio-medical assumptions.

6.1 Limitations of Current Research

Although the research targeted multiple perspectives, there was question of whether the sample attracted those who were resistant to change. Another limitation was the inability to tease out between perspectives of different layers of employees. As an example, one participant began the change journey as a direct service provider, ended up a member of the management team by the end, and also took part in the recovery change team. Therefore, the researcher was unable to adequately discern between perspectives based on participants' employment orientation alone. Finally, while the research in this analysis aids in understanding the broader landscape of recovery organizational change, the analysis was specific to the participating agency and may not be representative of other organizations.

6.2 Implications for Practice

There are broad implications for practice that emerged from this analysis. For all staff of community-based mental health service organizations, there is a call for increased reflection to critically examine the power dynamics of the bio-medical model, assumptions about recovery like implications of including peer professionals, and deep reflection of one's fears that naturally emerge from significant change. If these assumptions and emotions remain hidden they continue to impact one's outlook of recovery, and can inhibit professional growth. Further, the recovery paradigm demonstrates how practice should broaden beyond micro-level interventions and address wider macro-level social oppression.

Specific to those in management positions, there is a need to take the above reflection one step further and examine how to encourage innovation and empower change, develop supervisory relationships that foster reflection and embrace leadership. Similarly for those in positions of executive leadership, there is a call to uncover salient assumptions at the mezzo-level and construct messaging to reinforce the desired change.

6.3 Future Research

The literature revealed an existing poverty of knowledge for recovery specific organizational change, and the researcher found it necessary to explore literature within both mental health and business management paradigms and literature bridging both paradigms were sparse at best. While the goal of this research was to better understand broader connecting threads between complex issues, a model for recovery organizational change remained undeveloped.

Specific to the challenges revealed in this analysis, there is a call for future research addressing professional development modules to encourage 1) understanding of recovery theory and practice; 2) how to develop recovery-specific supervisory skills; and 3) development of recovery leadership skills.

Recovery oriented change efforts should not be limited to service providing organizations. As Peebles et al (2009) indicated, academic institutions that prepare students for work in the mental wellness fields must also be transformed. Given the understanding of the dominance of bio-medical assumptions, developing alternative preconceptions prior to engaging in the work will be critical to system wide recovery philosophy dissemination.

Finally, issues related to stigma must be addressed, be it in the hesitance to hire peer professionals or social marginalization and oppression, continued work to creating inclusive communities are imperative.

REFERENCES

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11-13.

Anthony, W. A., & Huckshorn, K. A. (2008). *Principled leadership in mental health systems and programs.* Boston, MA: Center for Psychiatric Rehabilitation.

Becker, D. R., Torrey, W. C., Wyzik, P. F., & Fox, T. S. (1998). Building recovery-oriented services: Lessons from implementing individual placement support (IPS) in community mental health centers. *Psychiatric Rehabilitation Journal 22*(1), 51-54.

Bird, V., Leamy, M., Le Boutillier, C., Williams, J., & Slade, M. (2011). *REFOCUS: Promoting recovery in community mental health services.* London: Rethink.

Borg, M., & Davidson, L. (2008). The nature of recovery as lived in everyday experience. *Journal of Mental Health, 17*(2), 129-140. doi:10.1080/09638230701498382

Burdette, N. (2012). Organizational change: Practical steps toward integration. *Mental Health Weekly: Essential Information for Decision-Makers 22*(20), 1-5. doi:10.1002/mhw.20330

Callaly, T., & Arya, D. (2005). Organizational change management in mental health. *Australasian Psychiatry, 13*(2), 120-123.

Carstairs, G. M. (1959). The social limits of eccentricity: An English study. In M. K. Opler (Ed.), *Culture and mental health* (pp. 373-389). New York: The Macmillan Company.

Cayley, D., & Sinclair, L. (1994). *CBC Ideas: Beyond Institutions.* Toronto: CBC Radio Works.

Clossey, L., Mehnert, K., & Silva, S. (2011). Using appreciative inquiry to facilitate implementation of the recovery model in mental health agencies. *Health and Social Work, 36*(4), 259-266.

Clossey, L., & Rowlett, A. (2008). Effective organizational transformation in psychiatric rehabilitation and recovery. *Journal of Social Work in Disability & Rehabilitation,7*(3), 315-339. doi:10.1080/15367100802487614

Cohen, D. S. (2005). *The heart of change field guide: Tools and tactics for leading change in your organization.* Boston, MA: Harvard Business School Press.

Cook, J. A., Shore, S. E., Burke-Miller, J. K., Jonikas, J. A., Ferrara, M., Colegrove, S., Norris, W. T., Ruckdeschel, B., Batteiger, A. P., Ohrtman, M., Grey, D. D., & Hicks M. E. (2010). Participatory action research to establish self-directed care for mental health recovery in Texas. *Psychiatric Rehabilitation Journal, 34*(2), 137-144. doi:10.2975/34.2.2010.137.144

Corrigan, P. W., Larson, J., Sells, M., Niessen, N., & Watson, A. C. (2007). Will filmed presentations of education and contact diminish mental illness stigma? *Community Mental Health Journal, 43*(2), 171-181. doi:10.1007/s10597-006-9061-8

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches.* (2nd ed.) Thousand Oaks: Sage Publications.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative and mixed methods approaches.* (3rd ed.) Thousand Oaks: Sage Publications.

Davidson, L., O'Connell, M., Tondora, J., Styron, T., & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services, 57*(5), 640-645.

Deane, F. P., Crowe, T. P., King, R., Kavanagh, D. J., & Oades, L. G. (2006). Challenges in implementing evidence-based practice into mental health services. *Australian Health Review, 30*(3), 305-309.

Drake, R. E., & Latimer, E. (2012). Lessons learned in developing community mental health care in North America. *World Psychiatry, 11*(1), 47-51.

Farkas, M., Gagne, C., Anthony, W., & Chamberlin, J. (2005). Implementing recovery oriented evidence based programs: Identifying the critical dimensions. *Community Mental Health Journal, 41*(2), 141-158. doi:10.1007/s10597-005-2649-6

Government of Ontario (2011). Open minds, healthy minds: Ontario's comprehensive mental health and addictions strategy. Retrieved October 2012 from http://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health2011/mentalhealth.aspx

Hamilton, A. B., Cohen, A. N., & Young, A. S. (2009). Organizational readiness in specialty mental health care. *Journal of General Internal Medicine, 25*(1), 27-31. doi:10.1007/s11606-009-1133-3

Hilton, T. F. (2006). Staff members are human subjects, too. *Journal of Substance Abuse Treatment, 31*(1), 9-15. doi:10.1016/j.jsat.2006.03.001

Horrobin, D. (2001). *The madness of Adam and Eve: How schizophrenia shaped humanity*. London: Corgi Books.

Kotter, J. P., & Cohen, D. S. (2002). *The heart of change: Real-life stories of how people change their organizations.* Boston, MA: Harvard Business School Publishing.

Kotter, J. P. (2008). *A sense of urgency.* Boston, MA: Harvard Business School Publishing.

Lammie, D., Harrison, T. E., MacMahon, K., & Knifton, L. (2010). Practitioner attitudes towards patients in forensic mental health settings. *Journal of Psychiatric and Mental Health Nursing, 17*(8), 706-714. doi:10.1111/j.1365-2850.2010.01585.x

Lehman, W. E. K., Simpson, D. D., Knight, D. K., & Flynn, P. M. (2011). Integration of treatment innovation planning and implementation: Strategic process models and organizational changes. *Psychology of Addictive Behaviours, 25*(2), 252-261. doi:10.1037/a0022682

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*(1), 363-385.

Mental Health Commission of Canada (2009). *Toward recovery & well-being: A framework for a mental health strategy for Canada.* Retrieved from http://www.mentalhealthcommission.ca/SiteCollectionDocuments/boarddocs/15507MHCC_EN_final.pdf

Morrow, M. (2013). Recovery: Progressive paradigm or neoliberal smokescreen? In B.A. LeFrancois, R. Menzies & G. Reaume (Eds.), *Mad matters : A critical reader in Canadian mad studies* (pp. 323-333). Toronto, ON: Canadian Scholars' Press Inc.

Mullaly, B. (2007). *The New Structural Social Work* (3rd ed.). Don Mills, ON: Oxford University Press.

Oades L. G., Crowe, T. P., & Nguyen, M. (2009). Leadership coaching transforming mental health systems from the inside out: The collaborative recovery model as person-centred strengths based coaching psychology. *International Coaching Psychology Review, 4*(1), 25-36.

Oliver, M. (1990). The ideological construction of disability. In *The politics of disablement* (pp. 43-59). London: MacMillan Press.

Onken, S. J., Craig, C. M., Ridgway, P., Ralph, R. O., & Cook, J. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal, 31*(1), 9-22.

Peebles, S. A., Mabe, P. A., Fenley, G., Buckley, P. F., Bruce, T. O., Narasimhan, M., Frinks, L., & Williams, E. (2009). Immersing practitioners in the recovery model: An educational program evaluation. *Community Mental Health Journal, 45*(4), 239-245. doi:10.1007/s10597-009-9212-9

Peirson, L. J., Boydell, K. M., Ferguson, H. B., & Ferris, L. E. (2011). An ecological process model of systems change. *American Journal of Community Psychology, 47*(3-4), 307-321. doi:10.1007/s10464-010-9405-y

Perkins, R., & Slade, M. (2012). Recovery in England: Transforming statutory services? *International Review of Psychiatry, 24*(1), 29-39. doi:10.3109/09540261.2011.645025

Piat, M., Sabetti, J., & Bloom, D. (2010). The transformation of mental health services to a recovery-oriented system of care: Canadian decision maker perspectives. *International Journal of Social Psychiatry, 56*(2), 168-177. doi:10.1177/0020764008100801

Raza, S. A., & Standing, C. (2011). A systemic model for managing and evaluating conflicts in organizational change. *Systemic Practice and Action Research, 24*(3), 187-210. doi:10.1007/s11213-010-9186-0

Ridgway, P. (2001). Restorying psychiatric disability: Learning from first person recovery narratives. *Psychiatric Rehabilitation Journal, 24*(4), 335-343.

Rockwell, G. (2011). The pain of mental illness is the stigma of mental illness. *Open* Minds Quarterly, 13(2), 26.

Ruffolo, M. C., & Capobianco, J. (2012). Moving an evidence-based intervention into routine mental health care: A multifaceted case example. *Social Work in Health Care, 51*(1), 77-87. doi:10.1080/00981389.2011.622674

Rychener, M., Salyers, M. P., Labriola, S., & Little, N. (2009). Thresholds' wellness management and recovery implementation. *American Journal of Psychiatric Rehabilitation, 12*(2), 172-184. doi:10.1080/15487760902813186

Salyers, M. P., Stull, L. G., Rollins, A. L., & Hopper, K. (2011). The work of recovery on two assertive community treatment teams. *Administration and Policy in Mental Health 38*(3), 169-180. doi:10.1007/s10488-010-0311-2

Sawyer, A. (2011). Let's talk: A narrative of mental illness, recovery, and the psychotherapist's personal treatment. *Journal of Clinical Psychology, 67*(8), 776-788. doi:10.1002/jclp.20822

Shepherd, G., Boardman, J., & Slade, M. (2008). Putting recovery into mental health practice. *Mental Health Today*, May, 28-31.

Smith-Merry, J., Freeman, R., & Sturdy, S. (2011). Implementing recovery: An analysis of the key technologies in Scotland. *International Journal of Mental Health Systems, 5*(11), 1-12.

Sowers, W. (2005). Transforming systems of care: The American Association of Community Psychiatrists guidelines for recovery oriented services. *Community Mental Health Journal, 41*(6), 757-774. doi:10.1007/s10597-005-6433-4

Svyantek, D. J., & DeShon, R. P. (1993). Organizational attractors: A chaos theory explanation of why cultural change efforts often fail. *Public Administration Quarterly, Fall,* 339-355.

The Roeher Institute. (1996). *Disability, Community, and Society*. Toronto: The Roeher Institute.

Thomas, J. R., & Fraser, V. V. (2009). Implementing evidence-based supported employment in a recovery-oriented mental health agency. *American Journal of Psychiatric Rehabilitation, 12,* 143-160. doi:10.1080/15487760902813129

Tutty, L.M., Rothery, M.A. & Grinnell, R.M.Jr. (1996). *Qualitative research for social workers.* Needham Heights, MA: Allyn and Bacon.

Uppal, S., Oades, L. G., Crowe, T. P., & Deane, F. P. (2010). Barriers to transfer of collaborative recovery training into Australian mental health services: Implications for the development of evidence-based services. *Journal of Evaluation in Clinical Practice, 16*(3), 451-455. doi:10.1111/j.1365-2753-2009.01141.x

Whitaker, R. (2002). *Mad in America: Bad science, bad medicine, and the enduring mistreatment of the mentally ill.* New York, NY: Perseus Publishing.

Whitley, R., Gingerich, S., Lutz, W. J., & Meuser, K. T. (2009). Implementing the illness management and recovery program in community mental health settings: Facilitators and barriers. *Psychiatric Services, 60*(2), 202-209.