Introduction

In Ontario, as in jurisdictions across North America, many stakeholders are calling for recovery to become the overarching philosophy and goal of the mental health system. The province's nine regional Mental Health Reform Implementation Task Forces have put recovery at the center of their recommendations (The Time is Now 2002). Across the province, a number of conferences and workshops have introduced recovery models to consumer/survivors, families, service providers, and system planners. Indeed, Ontario would seem to be squarely in the midst of the "creating buzz" stage of recovery implementation (Jacobson & Curtis 2000).

A highly complex, multi-faceted phenomenon, recovery may be conceptualized as having individual-level, organizational-level, and system-level components (Jacobson 2004). To date, much research has been devoted to understanding recovery as an individual-level process (e.g., Recovery Advisory Group 1999; Smith 2000; Ridgway 2001) and to formulating practice guidelines for providers wishing to work with their clients in a recovery framework (e.g., Ohio Department of Mental Health 1999; Curtis 2000; Ahern & Fisher 2001; O'Hagan 2001). Additionally, there has been a fair amount of work devoted to developing system-level requirements and strategies for recovery implementation (e.g., Anthony 1993; Anthony 2000; Jacobson & Curtis 2000) and several groups are devising performance indicators for assessing recovery at the system level (e.g., Onken 2003; O'Hagan 2003).

Mental health services organizations are key to promoting recovery, but relatively little has been done to understand what recovery means at the organizational level. Early

on, Daniel Fisher (1993) noted the importance of promoting a "positive culture of healing" in mental health services organizations and described some implementation strategies for managed care organizations seeking to promote recovery (Fisher undated document). Torrey and Wyzik (2000) have explored some of the implications of a "recovery vision" for community mental health centers. One conceptual model of recovery has attempted to delineate the qualities of Fisher's organizational culture of healing as they relate to recovery promotion (Jacobson & Greenley 2001). Jacobson, Greenley, Breedlove, Roschke, and Koberstein (2003) have used this conceptual model to develop a recovery-focused, organizational-level participatory evaluation and planning process for mental health services agencies.

This paper looks at one attempt to focus on recovery in an organization. Using a participatory action research approach, a mental health services researcher joined with the executive director, staff, clients, and board members of a community-based mental health services agency to explore how the agency might become more recovery oriented. The body of the paper describes the context, conduct, and findings of this participatory action research project. In the discussion, a number of individuals involved with the project offer perspectives on the research and the effort to implement recovery principles at the organizational level.

Background

Alternatives: The East York Mental Health Counselling Services Agency is a community-based mental health services agency located in Toronto's east end, a diverse neighbourhood that includes many immigrants and lower income families. Alternatives

was founded in the wake of the Graham Report (1988), when a community-wide planning process identified local needs for community support and case management services. The agency, which opened in 1994, has in recent years expanded beyond its original mandate and currently is involved in a wide range of programs, including drop-in, homeless and immigrant outreach, low income housing development, and work initiatives. It also is a partner in, and provides space to, the Consumer/Survivor and Family Leadership Project. Alternatives has a staff of 8 who provide services to approximately 150 individuals living in the community.

In July 2002, Alternatives was one of the sponsors of a Toronto forum convened to discuss the meaning and implications of recovery in the mental health system. The first two authors of this paper were panelists at that forum, and both saw opportunities for collaboration around the issues raised while implementing recovery principles in a mental health agency. After a series of initial discussions involving the staff, board of directors, and clients of Alternatives, a decision was made to begin a participatory action research project in the agency. The goals of this project were: to explore the meaning of recovery to members of the Alternatives community; to investigate the likely organizational facilitators of and barriers to recovery; and to develop specific organizational policies and practices that would aid the agency in promoting recovery. In the manner of most participatory research, of course, these goals were seen as preliminary guides that would be subject to modification as the project progressed.

The Research Process

The research proceeded through a series of phases. First, as indicated above, the researcher and the executive director met with staff, board members, and clients. These discussions aimed to assess whether members of the Alternatives community would be interested in the type of project that was being proposed and to learn what they saw as important issues to be pursued through research. In addition, the researcher did a brief presentation on recovery for a group of clients and a packet of readings about recovery was mailed to all staff, board members, and clients. The outcomes of these first steps were broad research questions and a rough plan for the next phases of the research.

With questions and plan in mind, the researcher and executive director sought and received REB approval for the project. Additionally, they signed a formal agreement laying out the terms of the research partnership. The partnership agreement described the rights and obligations of each party and listed a number of principles that would guide the research.

In the second phase, all members of the Alternatives community were invited to participate in focus groups. The researcher conducted four focus groups: one group with agency staff (n = 6), one with members of the board of directors (n = 6), and two with agency clients (n = 12). The staff focus group was held during regular working hours; clients and low-income board members were offered honouraria of $20 for their time. All participants provided written consent. The focus group discussions were structured by the following questions: What are Alternatives' clients recovering from? What does

recovery look like? What helps people to recover? What is Alternatives already doing to promote recovery? What more could the agency do?

After the focus groups were completed, the researcher developed a synthetic summary of the results, and then presented this summary at a meeting that was open to all members of the Alternatives community. In the course of this meeting, participants discussed the findings and highlighted several areas that they saw as most important for future action. Two more community meetings were held to talk about these issues and to begin to make plans for how they might be addressed. A decision was made to form four working groups, each devoted to researching and making recommendations relevant to one area of identified concern.

At this stage, however, enthusiasm began to wane, and it became clear that for many participants the endless process had become a source of frustration. One board member suggested that the time had come to stop talking and do *something*—that people would once again be interested in participating when they could see that their efforts were going somewhere. Accordingly, a small group that had continued to attend meetings decided to focus on one area that had been identified in the larger community discussions. This core group of about 9 people (researcher, executive director, staff, board members, and clients), together with several individuals who participated on a more casual basis, now shifted to information-gathering and decision-making around program development in this area.

The Findings: Recovery in Community

The Focus Groups

Focus group discussions of what Alternatives' clients are recovering from touched on the topics of specific disorders and symptoms, but issues of life challenges and the broader social context seemed more salient. Alternatives' clients have had difficult lives. Many grew up in abusive homes and have replicated these situations in their adult lives. They see themselves as constrained by their pasts, by poverty and lack of education, by low self-esteem, and by a dearth of coping skills. Societal injustice—in particular, the social barriers caused by stigma and discrimination—exacerbate these conditions.

Staff, board members, and clients agreed that recovery was a process, but there were some differences in their ideas about the nature of the process. Many staff members described recovery as a process of revisiting the past in order to shift perspective and change present responses. Recovery thus was demonstrated in changed attitudes and new accomplishments in areas like relationships, education, and employment. Board members were particularly interested in positive changes in symptoms and demeanour. For clients, recovery was the movement toward greater involvement in the world: being able to work and achieve financial security, feeling happy, living "like an average person," being treated with dignity and respect, or, as one participant said, "getting a better quality of life and becoming a full member of society."

There were many ideas about what helps people to recover. Both clients and board members noted the importance of medication. Clients, along with staff, also emphasized the usefulness of social support and counseling. Clients talked about the need

to end stigma and discrimination and to improve access to resources. All three groups agreed that environments that are safe, positive, hopeful, and non-judgmental promote recovery. They all saw recovery as something that happens not just within individuals or between clients and counselors, but in community.

The theme of community also arose in the focus group discussions of what Alternatives was already doing to promote recovery. Staff, board members, and clients agreed that in addition to providing high quality services (e.g., friendly, knowledgeable, and helpful counselors, medication consults with an excellent psychiatrist) the agency was doing a good job of integrating community—broadly defined--into its work. For example, board members praised new programs that had increased outreach to newcomer and ethno-racial minority communities. Staff talked about the pleasure of interacting with clients at agency-sponsored social events, like a recent holiday party. Clients were appreciative of Alternatives' open-door policy—in particular, of the hours available for drop-in and the free computer access.

Participants' suggestions for what more Alternatives could do to promote recovery also revolved around community. Board members wanted to see more agency-wide education about recovery. Clients wanted more of the things they saw as promoting their feelings of being part of a community: more computers, more social activities, and longer drop-in hours. Staff saw the value of social recreation programming and drop-in, but, in the case of the former, worried that they were doing too much "baby-sitting" of clients and, in the case of the latter, were very aware of the ways in which the open-door policy sometimes impinged on their own needs for time and space and led to feelings of being overwhelmed.

The Community Meetings

Rich discussions in the community meetings provided further analysis and elaboration of the focus group findings. Participants identified the following five overarching issues as priorities for further development of the organization's recovery orientation: increased support for clients in crisis; the meaning and practice of flexibility in service provision; the development of client-initiated and run services within Alternatives; the need for more education and skill development among clients; and the challenge of organizational change in a climate of scarce resources.

Accordingly, the planned next step was to be the formation of four working groups, each devoted to issues or actions related to the identified priorities. One group would look at resources and resource allocation. A second would focus on the general topic of promoting community within the agency. The third would examine the problem of how to increase drop-in hours without adding to staff burden. The last group would investigate the possibility of initiating new services to be organized and run by clients.

As described earlier in this paper, at this point, attendance and interest began to decline. A smaller group of participants made a decision to forego the multiple working groups and just do something. In discussions among this group, it became clear that the greatest enthusiasm was for the idea of starting some sort of client-run programming within the agency. As well, this focus seemed to address many of the priority areas identified earlier in the process. That is, initiating such programming would require the development of client skills. Client-run programs could increase the agency's flexibility and its ability to deal with crises. Clients might be able to take on responsibility for drop-

in, thus reducing staff burden and increasing the feeling of community. Finally, the development of new programming would require engaging the issue of resources.

The Planning Group

For the next several months, a core group composed of the researcher, board members, staff, and clients held monthly meetings to plan the development of client-run programming within Alternatives. (Interestingly, even in the temporary absence of the executive director—who was on parental leave--this process proceeded fairly smoothly.) The group investigated different models for the provision of client-run services by conducting a literature review, taking an environmental scan of training and support resources available in the community, and doing group interviews with people actively involved in the various models. (Jill Barnes describes these activities in detail in her essay.) At the conclusion of this process, the group discussed its options and decided which model would work best at Alternatives—that is, which model would be most helpful to the overall aim of promoting recovery in community.

The Decision

After discussions within the planning group and in one more community meeting, there was a general (although not entirely unanimous) agreement that the Wellness Recovery Action Plan (WRAP) program developed by Mary Ellen Copeland (1997) was the best choice for the agency. WRAP--grounded in recovery concepts like hope, self-determination, and interpersonal connection--is an educational process that helps individuals to recognize their own strengths and coping strategies and develop plans for using these strengths and strategies to respond to daily difficulties and symptom "triggers." (WRAP is further described in Jill Barnes's essay.) The WRAP program can

be used by individuals, in one-on-one work between clients and providers, and in small groups. For Alternatives, the small group format seems ideal for building the sense of camaraderie and mutual support characteristic of recovery in community. Indeed, the latest iteration of WRAP seeks to enhance the peer support implicit in the program (Copeland & Mead 2003).

Alternatives is fortunate that Ann Thompson, a Toronto consumer/survivor with a background in adult education and social work, has recently been trained by Copeland and is eager to facilitate a WRAP program at Alternatives. (We believe this will be the first use of WRAP in Toronto.) Beginning this summer, Ann will lead an 8-week WRAP series for up to 15 members of the Alternatives community. Where those individuals take WRAP next is up to them, but in addition to the personal benefit, the possibility exists that a new peer support group may develop, or that WRAP-trained individuals will become resources to Alternatives and the broader mental health community in Toronto, available, for example, to speak about the program to other groups that are considering implementing WRAP.

Discussion

Jason Altenberg

This research project has been challenging and exciting in many ways. It has been exciting to engage our community in a discussion of the meanings of recovery and to really look at how we might deepen the services to our community. The research process has been most valuable and has meant that we have been able to really evaluate our agency through a "recovery lens" in a way that is both authentic and will result in change.

One of the most profound challenges for me has been the need to balance the different needs of different parts of Alternatives organization. There was much common vision in the evaluation and defining process and yet some key differences as well. The staffs' need for a work place that was a place of support and respite in a very demanding and sometimes overwhelming work-life seemed at first incompatible with the desire of members to increase access and programming. The need for broader group and community access and the overwhelming individual support work and an on again off again wait list for services seemed at odds.

Compounding this issue is the practical reality of Ontario's mental health system. Ours is a system that is under-funded and shrinking due to an absence in base budget increases to community mental health programs in well over a decade. The constant pressure to do more with less has resulted in a reduction in physical space for our organization (fortunately, and unlike many similarly funded organizations, we been able to maintain program and staff levels). The need for this space for community gathering and informal support is clearly part of our recovery vision and something we are committed to, despite the real limitations in available space. Maintaining such community spaces is something that some organizations have done away with, as budgets allocated to rent do not go as far as they did over a decade ago.

While recovery can and does occur in the presence of scarcity there is no doubt to me that scarcity is a significant hurdle in the path. So much so in fact that it is indeed difficult to focus on programming and services given the financial poverty that is the reality of living on disability support in Ontario. The necessity to support the rights of consumers/survivors to adequate housing, access to meaningful employment and/or a

living wage via financial supports is essential to recovery and for some the only missing component to their personal recovery vision. Thus the need for services to be active in advocacy efforts that may ultimately make some services and programming obsolete and force others to expand and change.

Along with these challenges has been a feeling of energy and hope. The process itself has been valuable to the individuals involved and it seems that we have been able to find a direction that will meet the needs of the organization as a whole. Creating more opportunities for peer support and new directions in programming has been both exciting and meaningful. We will be creating a formal avenue for what has been for many an essential part of their experience of community at Alternatives. I am curious to see if this formal structure helps to build community for more of our members, specifically for members who have not yet used our organization as a place to create friendships and social connections.

Jill Barnes

Webster's Dictionary: "Recover—to grow well."

We had different community speakers who spoke of what self-help groups they had and how it worked for them: a self-help group for schizophrenia; the guide to self-help/peer support groups from the Mood Disorders Group of Ontario; information from the Ontario self-help network. We had two speakers come to talk about the co-counseling model and how it might work at Alternatives. It was how to get in touch with your feelings and how to verbalize them. Another speaker talked about a behavior

modification program—WRAP, the Wellness Recovery Action Plan—which is a U.S. model.

We discussed what we thought we would like to have Alternatives for a client-run/peer support group or program to help in recovery. We wanted to make it available to everyone and all different types of mental illnesses in our community. We spoke of the different ways to train people for the peer support activities and groups and whether to have staff help us facilitate them. We spoke of people needing to be fairly stable and in control or it could be harmful or dangerous to others if someone became too volatile. A safety back-up plan would need to be in place.

The schizophrenia self-help group said they originally consulted with Community Resource Consultants of Toronto. They tried to look after groups' emotional needs, their needs for information and discussion, and also linked up people with community supports. They helped them with needs like housing, legal, balancing their budget, employment, social groups, etc. Their format involves individual sharing and support to members with no pressure to participate. As well, there are occasional speakers and group discussions on relevant topics that the members decide on. Their goals are promoting friendship amongst the group and to educate about their illness. They decided on group guidelines, rules, and values. They also check in with members by phone and remind them of the next meeting. Sometimes they decide to go out after the meeting. They go to a restaurant or to someone's apartment close by to play a board game or do some computer activities. We spoke of the history of the group and facilitators.

The Mood Disorders Association of Ontario modeled their Self-Help/Peer Support groups on the Ontario Self-Help Resource Centre Network for ideas. The

Ontario Self-Help Resources Centre suggest this plan: research; planning and developing; leadership people; a group contact person; recruiting members; how to promote and advertise the group; ground rules and confidentiality; group meeting agenda; ideas for group exercises to get people in the group motivated, involved, and participating; whether you want speakers and how to organize it; evaluating your group to make sure it meets the group's needs; issues, concerns, and challenges in self-help groups; what if…? And how to deal with different situations that might come up; how to have a conversation about conflict in groups; how to sort out conflicts, even conflicts about how the group is run (e.g., conflicts about power, conflicts about membership); how to prepare for and manage crisis in a group; grief, mourning, and bereavement; using the internet; and developing a mission statement for the group.

The Wellness Recovery Action Plan (WRAP) is based on behaviour modification and the use of five key resource concepts: hope, personal responsibility, self-advocacy, education, and support. WRAP is based on people taking responsibility for their own wellness by self-monitoring and responding to symptoms to achieve the highest levels of wellness by using a workbook as outlined by the WRAP program. It teaches you about goals and objectives and YOU and ONLY YOU develop your own recovery plan by following the workbook course. "In this work you learn through your own experience and the experiences of others."

But, WRAP requires a lot of motivation, concentration, what could be physically draining written work, dedication, commitment, and the personal knowledge of how to help yourself. You need to have a basic awareness of your mental illness(es) in order to do this program: "You figure out for yourself a work plan for your recovery. It is self-

determined. You learn about your options, opportunities, and it is a place to learn more about yourself." The guide for WRAP is briefly stated as: Getting Started—paper, pen, binder with dividers; Your Daily Maintenance List--your feelings and how to keep yourself feeling alright and how to achieve this; Your Triggers—a triggers list and how to deal with them; Early Warning Signs—writing down your early warning signs you've noticed; Your Action Plan—using the workbook and designing your own action plan; Things are Breaking Down or Getting Worse—making a list of symptoms and developing an action plan with your tool book; Crisis Planning—write a crisis plan when you are well to instruct others about how to care for you when you are not well; Developing Your Post-Crisis Worksheet. As you can tell, this involves a lot of work. I know because I started and never finished a behavior modification program with workbook myself about four years ago. I listened to the videos and cassette tapes and felt overwhelmed by all the written work.

The research we did to find out how to start a peer support/peer activities group that would work for Alternatives was also a lot of work. What we will choose and decide needs to be right and personalized for us and fit our basic needs.

I found the process to be a great learning experience.

Rob Cusson

As a member of Alternatives I feel very honoured and grateful in having been part of the process in the recovery model.

I felt very taken, as a member, that our opinions really mattered and that we were made very included in the whole process of recovery. Focus groups were formed and the

process started with all our opinions and feedback. With much process, we defined what recovery meant to us. Everyone had a different take on recovery, as such a model is a very personal thing.

My own personal recovery strategies would definitely include the physical, as well as the spiritual. I really feel that one has to be all-inclusive in the journey to recovery. My fitness program, in all its many forms—weights, jogging, cycling, and yoga—are all so important to my mental stability. I strike to maintain my spiritual side with meditation, visualization, affirmation, smudging, and prayer.

Two forms of practical recovery strategies that I suggested at the focus groups and that I truly believed in and felt so strongly about are self-help support groups and peer counseling.

One should develop a recovery plan on their wellness path with strategies for their healing journey that can be revisited periodically. As one strategizes a well thought out plan of action for a successful career, as survivors of the mental health system, one should also have a well-developed plan for our wellness recovery model.

I was very moved and touch by being included in the term of individuals—executive director, staff, board members, consultant—that went to Niagara Falls and described our recovery work to an attentive, full audience at a mental health conference. It was a very rewarding experience which made me feel part of the process and very grateful and proud to be a member of Alternatives.

It seems that recovery is the hot topic of the day and you can't but help hear everyone talking about it—the fad of the day, the buzzword. Is it something people will

cling to and adopt? Will society develop and adopt such concepts? Will this be our new model of healing?

I really feel that if someone is really serious about their recovery and healing themselves one has to undergo a whole transformative, holistic process. One has to develop a wellness lifestyle that is very real to them, that fits their individuality and that becomes part of their routine activities, that they enjoy and feel good about—a feel good lifestyle that encompasses all aspects of life: a good diet, good sleep, exercise, stress free and positive thinking attitudes, laughter and joy.

I'm really looking forward to being part of this whole process of alternative healing and part of a team at Alternatives that will continue to develop the recovery model. I'm really glad to be a member of Alternatives, leading in the path of such an innovative and progressive model of healing.

Let us do it!

Nora Jacobson

The Alternatives project has posed many challenges. Involving an entire agency in research necessitates a significant investment of time and effort just to accomplish basic tasks. For example, each time we scheduled a meeting, we had to send a mass mailing to inform people of the time and place. These long lead times often interrupted momentum. When new people came to a community meeting, we repeated material already covered in previous meetings. Like many others involved in the project, I found it easy to tire of so much process!

A second challenge has been learning to relinquish control. Although I shared some of their feelings, I felt responsible when participants' interest in the work waned.

At times I have been frustrated by the gap between our initial expectations for the project and its relatively modest result. The "findings" have not been earth shattering. I have realized, however, that sharing responsibility for the conduct of research means that I do not bear sole responsibility for its result. Too, what seems modest to me has been very significant for others involved in the project. I have also found it exciting that when commitment has waned someone has always stepped up to take on a leadership role.

We began the work described in this paper when I was still new to Toronto—a city notorious for being tough on newcomers. I feel very grateful to the people at Alternatives for making me feel a part of their community.

Virginia Rowley

Alternatives' Board of Directors has been introduced to the recovery model of care. Nora Jacobson has taken the Board through focus groups and has led discussions on this particular philosophy. Before beginning a discussion of the Board's role in this process, it is significant to recount the type and role of the Board of Alternatives.

The Board of Directors of Alternatives functions in a governance capacity. In carrying out this role, the members further the objectives of the agency and are accountable to the membership. They create committees to advise on policy. The primary responsibility of the Board is to establish and monitor the vision, mission, guiding principles, and strategic goals of the organization. The Board has a critical role to play in ensuring that all the activities of the organization are aligned with the vision, mission, and goals. The key principles of stewardship, leadership, delegation, and monitoring are applied to this process.

The recovery model is consistent with the values of Alternatives. Alternatives is committed to enabling adults to realize their potential through counseling and case management, with respect and awareness of the consumer/survivor as the expert of their own lives. The model respects and acknowledges the unique responses of individuals. Key concepts of recovery are hope, personal responsibility, and self-advocacy. The participants learn through their own experience and the experience of others. Alternatives has played a leadership role in responding to the needs of its ethnoracial communities. The recovery model provides the flexibility for Alternatives to continue to respond to a changing community.

The Board was adamant that the processes of addressing recovery not interfere with the quality of the services available to clients. The agency has been very successful at focusing on both the needs of the individual and the person in their environment. There is a recognition of and participation in diversity.

The Board has a responsibility to be kept informed of changes within the agency. The Board has taken personal responsibility to learn and educate itself about issues in which the agency is involved and has asked for educational input. The Board has been involved from the time that this model was proposed by the Mental Health Reform Implementation Task Force, through the research process to the current information sessions. It is important that the Board has an overview, and this has happened. This is consistent with the Board's focus on ends, while the staff has the responsibility for the means.

The Board was concerned about fiscal and administrative implications of the recovery model in the context of recent constraints in the health care system. Looked at

in terms of funding dollars, will it require more staff, a more intensive approach, or will it broaden the role of staff?

Another responsibility of the Board is to ensure that the agency is proactive in responding to government legislation. The agency responded to questionnaires and submitted feedback to the regional Mental Health Reform Implementation Task Force. The Task Force put forth recovery as one of their recommendations. The Board has recognized the political movements that have impacted on the mental health system and are ensuring that Alternatives is playing a leadership role.

This leadership role is increasing the profile of the agency in the mental health community. This will lead to recognition of services that will better service the consumer/survivors in this geographic area.

It has been an enlightening experience for the Board to be involved in this research project. The Board wishes Alternatives success in following through with this model.

References

Ahern, L. & Fisher, D. (2001). "Recovery at Your Own PACE (Personal Assistance in Community Existence)." *Journal of Psychosocial Nursing*, 39 (4), 22-32.

Anthony, W.A. (1993). "Recovery from Mental Illness: The Guiding Vision of the Mental Health System in the 1990s" *Psychosocial Rehabilitation Journal*, 16 (4), 11-23.

Anthony, W.A. (2000). "A Recovery-Oriented Service System: Setting Some System Level Standards." *Psychiatric Rehabilitation Journal*, 24 (2), 159-168.

Copeland, M.E. (1997). *Wellness Recovery Action Plan*. Brattleboro, VT: Peach Press.

Copeland, M.E. & Mead, S. (2003). *WRAP and Peer Support*. Brattleboro, VT: Peach Press.

Curtis, L.C. (2000). "Practice Guidance for Recovery-Oriented Behavioral Healthcare for Adults with Serious Mental Illnesses. In *Personal Outcome Measures in Consumer Directed Behavioral Health*. The Council on Quality and Leadership in Supports for People with Disabilities. Towson, MD.

Fisher, D.B. (1993). "Towards a Positive Culture of Healing." The Department of Mental Health Core Curriculum: Consumer Empowerment and Recovery, Part I. Boston, MA.

Fisher, D.B. (undated) "Self-Managed Care: Ways that Managed Care Organizations and Their Partners Can Promote the Participation of Consumers in Their Recovery." Lawrence, MA: National Empowerment Center.

Jacobson, N. (2004). *In Recovery: The Making of Mental Health Policy*. Nashville: Vanderbilt University Press.

Jacobson, N. & Curtis, L. (2000). "Recovery as Policy in Mental Health Services: Strategies Emerging from the States." *Psychiatric Rehabilitation Journal*, 23 (4), 333-341.

Jacobson, N. & Greenley, D. (2001). "What is Recovery? A Conceptual Model and Explication." *Psychiatric Services*, 52 (4), 482-485.

Jacobson, N., Greenley, D., Breedlove, L., Roschke, R., and Koberstein, J. (2003). "Guided Reflection: A Participatory Evaluation and Planning Process to Promote Recovery in Mental Health Service Agencies." *Psychiatric Rehabilitation Journal*, *27* (1), 69-71.

O'Hagan, M. (2001). *Recovery Competencies for New Zealand Mental Health Workers*. Wellington, NZ: Mental Health Commission.

O'Hagan, M. (2003). "Values Based Practice and Recovery: A New Zealand Perspective." Presented at the International Institute of Mental Health Leaders. Birmingham, England. June.

Ohio Department of Mental Health. (1999). "Emerging Best Practices."

Onken, S. (2003). "Mental Health Recovery: What Helps and What Hinders? A USA National Research Project for the Development of Recovery Facilitating System

Performance Indicators." Presented at the World Federation for Mental Health Biennial Congress. Melbourne, Australia. February.

Provincial Community Mental Health Committee (1988). *Building Community Support for People: A Plan for Mental Health in Ontario*. (Graham Report). Toronto.

Recovery Advisory Group. (1999). "Recovery Model: A Work in Process." Accessed at www.mhsip.org.

Ridgway, P. (2001). "ReStorying Psychiatric Disability: Learning from First Person Recovery Narratives." *Psychiatric Rehabilitation Journal*, 24 (4), 335-343.

Smith, M.K. (2000). "Recovery from a Severe Psychiatric Disability: Findings of a Qualitative Study." *Psychiatric Rehabilitation Journal*, 24 (2), 149-158.

The Time is Now: Themes and Recommendations for Mental Health Reform in Ontario (2002). Final Report of the Provincial Forum of Mental Health Implementation Task Force Chairs.

Torrey, W.C. & Wyzik, P. (2000). "The Recovery Vision as a Service Improvement Guide for Community Mental Health Center Providers." *Community Mental Health Journal*, 36 (2), 209-216.