

THE TRANSFORMATION OF MENTAL HEALTH SERVICES TO A RECOVERY-ORIENTATED SYSTEM OF CARE: CANADIAN DECISION MAKER PERSPECTIVES

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Abstract

Background—Recovery is emerging as a worldwide paradigm in mental health. There is increasing recognition that the transformation of mental health systems to a recovery perspective requires collaboration among all stakeholders. Research to date has focused on the perspectives of service users and providers. The role and influence of organizational decision makers in the transformation process has been less studied.

Materials—This study reports findings from semi-structured interviews with decision makers on the implementation of recovery in Canada.

Discussion—Decision makers view community-based services as most open to recovery-based approaches, and front-line providers as pivotal in implementing system change. Decision makers described their own role as limited to providing overall orientation and funding.

Conclusions—The shift to recovery must include active leadership from decision makers as a catalyst to change.

Keywords

mental health; recovery; decision makers; system reform; Canada

INTRODUCTION

Recovery is emerging as a worldwide paradigm in mental health, challenging traditional, biomedical models of care. Recovery was first described by mental health consumers who began publishing on their own recovery experiences in the late 1980s. Patricia Deegan was one of the first to write about recovery as a transformative experience that goes far beyond a ‘restitution’ or ‘back to health’ narrative (Deegan, 1988; 1997; 2001). Writings have

associated recovery with hope, acceptance and engagement (Ridgway, 2001); connectedness (Ahern & Fisher, 2001; Frese & Davis, 1997); self-determination and shared decision making (Deegan, 2007; Deegan & Drake, 2006; Frese & Davis, 1997; Schauer *et al.*, 2007); supportive psychiatric relationships (McGrath & Jarrett, 2004); and peer support (Solomon, 2004). Recovery is described as a way of living a satisfying, hopeful, contributing life, despite psychiatric disability or symptoms.

There is increasing recognition that the transformation of mental health systems to a recovery perspective requires collaboration among all stakeholders connected with mental health organizations, yet research to date has focused largely on the perspectives of service users and providers. The role and influence of system-level and organizational decision makers in the transformation process has been less studied, although interest in leadership is beginning to emerge (Anthony & Huckshorn, 2008). This article reports findings from a study involving Canadian decision makers on issues around the implementation of recovery in Canada. (This study was funded by the Canadian Institutes of Health Research Project #7451.)

Implementing recovery: an overview of national strategies

North American and Commonwealth countries, led by New Zealand and the US (Ramon *et al.*, 2007), have established recovery as the basis of system transformation. Implementation of recovery varies, however, as countries come to grips with different challenges. For example, the US President's New Freedom Commission (2003) identified a fragmented mental health system and gaps in care as obstacles to recovery (Hogan, 2003); whereas planning documents in New Zealand identify discrimination and stigma as most problematic (Mental Health Commission, 2007). Combating stigma is also a central focus in Australia's *Framework for the Implementation of the National Health Plan 2003–2008* (Commonwealth of Australia, 2004). Implementation in Australia combines a strong commitment to recovery-orientated research and programming with the development of culturally sensitive practice within a population-health approach.

Aside from prioritizing the recovery concept in mental health policies, implementation of recovery has focused on transforming state and local services, and promoting better outcomes and measurable standards. Following major system restructuring, New Zealand (2007) reported increased accountability, cooperation and cost-effectiveness in services. In the U.S, where a dozen states had already been promoting recovery-orientated mental health systems by the mid-1990s (Jacobson, 2003), all 50 states quickly adopted recovery mission statements and were implementing at least one evidence-based service following publication of the 2003 Commission Report (Lutterman *et al.*, 2004). A recovery model from the state of Ohio (Townsend *et al.*, 1999) has been promoted internationally (Bonney & Stickley, 2008). The most comprehensive U.S. state-wide reform effort occurred in Connecticut, producing a mission statement, programme and practice standards, centres of excellence, and research instruments measuring different dimensions of recovery (Davidson *et al.*, 2007).

Consumer-driven services are another priority of recovery-orientated mental health systems. Ramon *et al.*, (2007) underline, in their comparative analysis of Australia and the UK, that consumer perspectives in both countries have significantly influenced the promotion of

recovery. The same could be said for the US, where an ‘evidence-based, recovery-focused, and user- and family-driven’ system was proposed (President’s New Freedom Commission on Mental Health, 2003). Consumer involvement has also influenced state level reforms (e.g. Jacobson, 2004). In New Zealand, good consumer–provider relationships are identified as a key quality indicator for recovery-orientated services. The 2007 New Zealand National Plan devotes an entire chapter to an expanded role for consumers, from participation to leadership.

Provider competency standards and training are another area of recovery implementation where considerable work has occurred internationally. Coursey *et al.*, (2000a; 2000b) first defined 12 core competencies for mental health providers based on recovery values. The American Association of Community Psychiatrists (Sowers, 2005) followed suit, publishing practice guidelines for its membership. The governments of New Zealand (Mental Health Commission, 2002) and Scotland (Schinkel & Dorrer, 2007), put forward recovery-orientated standards for mental health workers. In the UK, interest in evidence-based practices has resulted in evidence-based guidelines for the mental health workforce (Department of Health, 2008); these guidelines may go far in shifting provider attitudes toward a recovery orientation.

In Canada, the only G8 country without a national mental health strategy (Kirby, 2008), the transformation to a recovery-orientated system is at an early stage. While the Senatorial Report, *Out of the Shadows at Last*, states that ‘recovery must be placed at the centre of mental health reform’ (Kirby & Keon, 2006), implementation rests with individual provinces and territories. A Mental Health Commission, established in 2007, has been mandated to develop a national mental health strategy. In this context, decision makers shared their views on the implementation of recovery in Canada.

METHODS

In this exploratory study, researchers conducted individual, semi-structured interviews with Canadian mental health users and decision makers, and led focus groups with service providers, on personal meanings of recovery and experiences with recovery-orientated services. (Findings on consumer perspectives are reported in Piat *et al.*, (2008) and forthcoming in Piat *et al.* (2009a); Piat *et al.* (2009b)). This article reports the perspectives of 10 key decision makers regarding the implementation of recovery-orientated services in Canada.

Setting

The study included three geographic areas: (1) Montreal, Quebec, at the Douglas Mental Health University Institute; (2) Ontario, Waterloo/Wellington-Dufferin regions, through the Canadian Mental Health Association and Self-Help Alliance, a consortium of user-run services; and (3) Quebec City, at PECH (*Programme d’Encadrement Clinique en Hébergement*), a community organization providing housing and crisis services to persons with serious mental illness.

All three sites were attempting to integrate recovery into their organizations at the time of the study. The Douglas Mental Health University Institute had identified recovery as the priority in its strategic plan (Douglas Hospital, 2006), and created an official recovery programme within its clinical services. In Quebec City, PECH described its services as strengths-based and recovery-orientated (*Programme d'encadrement clinique et d'hébergement*, 2007). In Ontario, the Canadian Mental Health Association (CMHA) had adopted a recovery 'model' (Townsend, 2005), while recovery is the *raison d'être* of the user-run Self Help Alliance. The Ontario and Quebec City sites had also implemented staff training programmes on recovery.

An Advisory Committee, including users, providers, health ministry representatives, and a Yale University researcher, oversaw the research. The Committee met three times between September 2005 and June 2007, validating the interview guides and research process.

Participant recruitment and selection

A list of all potential decision makers from each site was compiled by the research team. Decision makers were those involved in mental health systems where the sites were operating. They represented three administrative levels: (1) policy makers at provincial ministerial levels; (2) senior administrators in regional planning organizations; and (3) senior administrators in large psychiatric facilities. Sample selection was purposeful. In order to ensure that each administrative level was adequately represented, the principal investigator initially contacted 12 decision makers from a list of 16, by letter, confirming their participation by telephone. Two decision makers were unable to participate. In all, 10 decision makers were interviewed between June and October 2007. The final sample included: two ministerial decision makers for the two provinces where the research sites were located (Quebec and Ontario); five senior administrators at the regional level; and three senior administrators from local psychiatric facilities.

Questionnaires

A 14-item interview guide was developed after consultation between the research team and Advisory Committee, and after a literature review. Questions included how services were/were not recovery orientated and how recovery could be implemented. A short sociodemographic questionnaire was administered after each interview.

Procedure

Interviews took place in participants' offices. They lasted between 60 and 90 minutes, were audio-taped, and transcribed verbatim.

Analysis

Data analysis was ongoing over four months and involved three distinct stages. First, team members read each transcript several times in order to identify patterns or commonalities in the data (Morse & Field, 1995). In the second stage, the transcripts were coded using substantive or open coding (Glaser & Strauss, 1967). All codes on the implementation of recovery were extracted and organized into 18 categories. In the third stage of analysis, the categories were reduced to six overall themes:

1. Agree on the definition of recovery.
2. Implement recovery in the community.
3. Hold providers responsible for recovery implementation.
4. Foster a new professionalism.
5. Get users involved.
6. Create recovery standards and outcome measures.

Specific efforts were taken to ensure the trustworthiness of the study. Data analysis was a shared process involving continual team discussion and feedback. A detailed audit trail including raw data (transcriptions), data reduction and data analysis materials (codebooks, memos, draft findings) was kept throughout the study. Findings from this study were presented to all participants.

Ethics

Ethics boards from each of the three sites approved the research. All participants signed and received a copy of the consent form. No identifying information has been used in reporting findings.

FINDINGS

Sample

Of the 10 decision makers, eight were male, with a mean age of 52 ($SD = 7.5$). Their academic backgrounds included social work and medicine (two from each), and psychology, public health, management, anthropology, nursing and theology (one from each). Three decision makers worked in provincial health ministries; four were planners with regional health agencies, and three were senior administrators in psychiatric hospitals. They had five years' experience, on average, in their current positions. Although none had received training in the recovery approach to mental health, findings presented below provide insight into how decision makers view the implementation of recovery in Canada.

Theme 1: Agree on the definition of recovery

Decision makers affirmed that there is considerable interest and discussion around recovery at regional and local level in Canada. They were aware of a certain 'belief' behind recovery as a 'fundamental value', and momentum toward institutional change. Nonetheless, they viewed definitions of recovery as either particular to individuals, or as vague and confusing, especially the distinction between 'recovery' and 'empowerment'. One stated that recovery needs to take hold as a guiding principle in service provision, but did not see much evidence of this happening. He found that definitions of recovery among decision makers varied:

I don't have the impression that much is being done to integrate the concept (into practice). Everyone has his or her own little definition ... I'm not even sure that the definition I gave you today is entirely accurate. (François)

For others, definitions have direct implications for establishing priorities in planning mental health services. If recovery is defined as an outcome, for example, then the emphasis should be on treatment, and the development of high-quality diagnostic services. Another decision maker cautioned that lack of agreement on the definition of recovery could, in itself, jeopardize system transformation:

I think that we're not well served ... 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 we 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. (Luc)

Theme 2: Implement recovery in the community

Nearly all decision makers viewed the recovery approach as more relevant and more easily implemented in community-based services rather than in hospital services. They identified Assertive Community Treatment, first psychosis programmes and community crisis intervention as examples of community-orientated services.

Decision makers offered several reasons why the recovery approach is a better fit with community-based services. Recovery is a more 'environmental' or 'social' approach to mental health, as compared with diagnostic or clinical approaches. Recovery-based services are closer to the 'real needs' of people, and provide a longer-term commitment to individuals. They described providers working in community services as more innovative, more willing to take risks and to challenge traditional approaches. Others viewed characteristics of community services, such as small teams and less formal settings, as more favourable to a recovery orientation:

Usually I find, the less formal the structure, the more you're able to do [recovery] ... So sometimes it's the really frontline people working in rural areas ... they're the ones that can really work more on that model, which is ironic. (Luc)

Decision makers also stated that hospitals are associated with illness; not the most appropriate setting for recovery. One described hospitalization as so traumatizing and stigmatizing that it should be a 'last resort' for people. For him, any service offered in the community was recovery-orientated. Another discussed how long-term hospitalization created 'chronicity'. Others argued that recovery is more difficult to implement, and less relevant, in acute-care settings.

Issues around staffing impeded recovery implementation in the hospital context. One decision maker characterized negative attitudes among hospital staff:

We can't handle it anymore; we've gone the limit; we've reached the 'Peter principle'. We're no longer able to treat these people. (François)

Another stated that hospital staff rarely develop meaningful relationships with clients, but instead focus on instrumental tasks and security issues. Frequent staff turnover and 24/7 shifts make it difficult to train staff in recovery-orientated practices.

Theme 3: Hold providers responsible for recovery implementation

Whereas decision makers described their role as establishing overall service orientations and allocating funds, they argued that service providers are best positioned to incorporate recovery values into services:

I think that it's within an agency, or in an organization even more so, that a decision maker has much more potential impact on the promotion of recovery, because of the choices available to him: how I set up my team; what basic training I'll provide; what organizational objectives I'm going to establish; with what results; and so forth. (Denis)

They added that providers working in local agencies are responsible for enhancing users' life prospects, and 'keep[ing] the flame [of hope] alive'. They viewed local providers as the best agents of change, as recovery-based approaches cannot be imposed from the outside:

It's [a recovery orientation] not going to come from the Ministry or the funder. It has got to come from the people that are working with the people. (Dean)

Theme 4: Foster a new professionalism

Decision makers spoke about fostering a new professionalism among providers, grounded in recovery values and practices. Some emphasized that the recovery orientation is *not* shared by everyone. One stated that providers would have to deal with their 'comfort or discomfort' around recovery, or the tendency toward inaction disguised as 'lack of readiness'. She asserted that, in order to ensure lasting change, providers must strive for more than an 'intellectual' understanding of recovery, infusing recovery values into practice.

Decision makers described the need to develop a new generation of mental health providers. One claimed that new opportunities to work in the community were creating a 'new breed' of doctors who were embracing the recovery vision. Another mentioned attrition in her organization as an opportunity to train the next wave of providers in the recovery approach, adding that universities should support this effort. A third decision maker recommended rewarding talent among existing workers in the system, especially younger workers who showed more openness to recovery, and could serve as role models for co-workers. Decision makers agreed that recovery training needs to occur at all levels of the system.

Theme 5: Get users involved

Decision makers identified users as the most credible spokespersons for recovery, citing user involvement on government planning committees in particular. One articulated that a recovery orientation requires genuine exchange, and mutual accommodation, between users and policy makers:

If we're going to push further with recovery, and I think there's no turning back, we must surround ourselves with service users ... I think what this does is ... create a balance between the system and the people who require services from the system ... and we have to reconcile the two. (Charles)

Another added that a recovery approach implies sharing power and resources among government officials, providers and service users. A third suggested that specific contributions of users are signs of a recovery orientation:

I would say that the participation of service users involves different stages: the definition, preparation, then the development of a service structure and interventions for them. These are probably the gauge of a more recovery-based approach to service delivery. (Brenda)

For one decision maker, contact with users was an eye-opening experience:

As a decision maker, I don't have much exposure to users in my daily activities. The fact that we had service users give presentations and serve on the organizing committee ... that was an indirect way of promoting recovery. (Denis)

Theme 6: Create recovery standards and outcome measures

Decision makers identified the need to measure how recovery was being implemented in services. One argued that evaluation methods and measures were more concerned with quantity or volume than quality. She proposed the establishment of 'accreditation teams' to assess how services were actually implementing recovery principles. Another stated that recovery should serve as the standard for the redesign of existing mental health services. Decision makers asserted that outcome measures could be used to demonstrate that recovery is possible for everyone.

DISCUSSION

Limitations of the study

This is the first known Canadian study of decision-maker perspectives on the implementation of recovery in mental health systems and services. Findings however need to be nuanced by certain limitations. The sample was small, and purposefully selected. The views presented cannot be generalized to all decision makers in Canada, although they do represent the perspectives of individuals who have considerable influence on the mental health system in the regions where they are working. Thus, these findings should be of interest to service providers, administrators and to some users, as Canada embarks on the process of transforming its mental health system.

Overall, findings suggest a pivotal role for frontline providers in translating recovery from theory to practice. Decision makers viewed community-based services as more appropriate to recovery-orientated practice, and their staff as more open to recovery than hospital staff. Providers working closest to users were said to have the expertise and organizational means to transform services. Decision makers envisioned the emergence of a new breed of university-trained professionals who will infuse recovery values and practices into the system. They called for performance standards and outcome measures as a way of holding providers accountable.

Despite the lack of a national mental health plan for Canada, decision makers portrayed an overall grasp of the requirements for transforming services to a recovery perspective in their

emphasis on workforce training, user participation and measurable standards. Their understanding that user involvement must reflect a genuine exchange and accommodation between users and policy makers, corresponds to demands of service-user movements internationally (O'Hagan, 2004).

Decision makers observed that definitions of recovery tend to be idiosyncratic, but, more importantly, that many providers have not 'bought into' the recovery vision and are using recovery language to describe the status quo. While the Kirby Commission provides a sufficiently clear definition of recovery to move forward, evidence-based provider competency guidelines are lacking in Canada. Such guidelines, available in England for example (Department of Health, 2008), would also begin to address problems of quality control and accountability in services.

The finding that decision makers did not associate recovery with hospital settings is somewhat surprising. Recovery is an overall vision and philosophy, and has been consistently described as involving all services, including hospital and rehabilitation services (Farkas, 2007). The other issue worth noting is that most decision makers did not foresee a leadership role for themselves in transforming the system. They see themselves as offering overall orientation and funding, while leaving implementation to providers. We question the wisdom of this perspective and would recommend that decision makers play a more responsible and active role in the transformation process. Influencing their peers, decision makers become powerful proponents of system transformation. Their leadership should acknowledge the recovery potential of all persons with psychiatric disabilities, and ensure authentic opportunities for users to infuse the knowledge of 'lived experience' at all levels of the system.

This is a first study. Future research should evaluate decision-maker roles in implementing recovery-orientated services and should also explore differences in how recovery is being implemented in community and hospital settings both in Canada and abroad.

References

- Ahern L, Fisher D. Recovery at your own PACE (personal assistance in community existence). *Journal of Psychosocial Nursing and Mental Health Services*. 2001; 39(4):22–32.
- Anthony, WA., Huckshorn, KA. *Principled Leadership in Mental Health Systems and Programs*. Boston: Boston University Center for Psychiatric Rehabilitation; 2008.
- Bonney S, Stickley T. Recovery and mental health: A review of the British literature. *Journal of Psychiatric and Mental Health Nursing*. 2008; 15:140–153. [PubMed: 18211561]
- Commonwealth of Australia. *Framework for the Implementation of the National Mental Health Plan 2003–2008 in Multicultural Australia*. Canberra: Department of Communications; 2004.
- Coursey RD, Curtis L, Marsh DT, Campbell J, Harding C, Spaniol L, et al. Competencies for direct service staff members who work with adults with severe mental illnesses in outpatient public mental health/managed care systems. *Psychiatric Rehabilitation Journal*. 2000a; 23(4):378–392.
- Coursey RD, Gearon J, Bradmiller MA, Ritsher J, Keller A, Selby P. A psychological view of people with serious mental illness. *New Directions for Mental Health Services*. 2000b; 88:61–72.
- Davidson L, Tondora J, O'Connell MJ, Kirk T Jr, Rockholz P, Evans AC. Creating a recovery-oriented system of behavioral healthcare: Moving from concept to reality. *Psychiatric Rehabilitation Journal*. 2007; 31(1):23–31. [PubMed: 17694712]

- Deegan P. The lived experience of using psychiatric medication in the recovery process and a shared decision-making program to support it. *Psychiatric Rehabilitation Journal*. 2007; 31(1):62–69. [PubMed: 17694717]
- Deegan PE. Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*. 1988; 11(4):11–19.
- Deegan PE. Recovery and empowerment for people with psychiatric disabilities. *Social Work in Health Care*. 1997; 25(3):11–24. [PubMed: 9358596]
- Deegan, PE. Part One: Consumer/survivor perspectives: Recovery as a self-directed process of healing and transformation. In: Brown, C., editor. *Recovery and Wellness: Models of hope and empowerment for people with mental illness*. Philadelphia: The Haworth Press Inc; 2001. p. 5-21.
- Deegan PE, Drake RE. Shared decision making and medication management in the recovery process. *Psychiatric Services*. 2006; 57(11):1636–1639. [PubMed: 17085613]
- Department of Health. Support, Time and Recovery (STR) Workers. A Competence Framework. London: Department of Health; 2008.
- Douglas Hospital. Recovery: From Neighbourhood to Neuron. 2006–2010 Strategic Plan. Montreal: Douglas Hospital; 2006.
- Farkas M. The vision of recovery today: What it is and what it means for services. *World Psychiatry*. 2007; 6(2):68–74. [PubMed: 18235855]
- Frese FJ, Davis WW. The consumer-survivor movement, recovery, and consumer professionals. *Professional Psychology – Research and Practice*. 1997; 28(3):243–245.
- Glaser, BG., Strauss, AL. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine; 1967.
- Hogan MF. The President’s New Freedom Commission: Recommendations to transform mental healthcare in America. *Psychiatric Services*. 2003; 54(11):1467–1474. [PubMed: 14600303]
- Jacobson N. Defining recovery: An interactionist analysis of mental health policy development, Wisconsin 1996–1999. *Qualitative Health Research*. 2003; 13(3):378–393. [PubMed: 12669338]
- Jacobson, N. *Recovery. The Making of Mental Health Policy*. Nashville: Vanderbilt University Press; 2004.
- Kirby M. Mental health in Canada: Out of the shadows forever. *Canadian Medical Association Journal*. 2008; 178(10):1320–1322. [PubMed: 18458265]
- Kirby, M., Keon, WJ. *Out of the Shadows at Last. Transforming Mental Health, Mental Illness and Addiction Services in Canada*. Ottawa: Sénat du Canada; 2006.
- Lutterman, T., Mayberg, S., Emmet, W. State Mental Health Agency implementation of the New Freedom Commission on Mental Health Goals: 2004. In: Manderscheid, RW., Berry, JT., editors. *Mental Health, United States, 2004*. Rockville: US Department of Health and Human Services, SAMHSA; 2004. p. 87-101.
- McGrath P, Jarrett V. A slab over my head: Recovery insights from a consumer’s perspective. *International Journal of Psychosocial Rehabilitation*. 2004; 9(1):61–78.
- Mental Health Commission. *Mental Health (Alcohol and other Drugs) Workforce Development Framework*. Wellington: Ministry of Health; 2002.
- Mental Health Commission. *The Journey of Recovery for the New Zealand Mental Health Sector*. Wellington: Mental Health Commission; 2007.
- Morse, JM., Field, PA. *Qualitative Research Methods for Health Professionals. 2*. Thousand Oaks, London, New Delhi: Sage Publications; 1995.
- O’Hagan, M. *Our Lives in 2014. A recovery vision from people with experience of mental illness for the second mental health plan and the development of the health and social sectors*. Wellington: With assistance of the Mental Health Commission; 2004.
- Piat M, Sabetti J, Bloom D. The importance of medication in consumer definitions of recovery from serious mental illness: A qualitative study. *Issues in Mental Health Nursing*. 2009a forthcoming.
- Piat M, Sabetti J, Couture A. Do consumers use the word ‘recovery’? *Psychiatric Services*. 2008; 59(4):446–447. [PubMed: 18378849]

- Piat M, Sabetti J, Couture A, Sylvestre J, Provencher H, Botschner J, et al. What does recovery mean for me? Perspectives of Canadian mental health consumers. *Psychiatric Rehabilitation Journal*. 2009b forthcoming.
- President's New Freedom Commission on Mental Health. *Achieving the Promise: Transforming mental health care in America*, final report. Rockville: US Department of Health and Human Services; 2003. No. SMA-03-3832
- Programme d'encadrement clinique et d'hébergement (PECH). *PECH intervenir autrement*. Rapport annuel 2006–2007. Quebec: PECH; 2007.
- Ramon S, Healy B, Renouf N. Recovery from mental illness as an emergent concept and practice in Australia and the UK. *International Journal of Social Psychiatry*. 2007; 53(2):108–122. [PubMed: 17472085]
- Ridgway P. Re-storying psychiatric disability: Learning from first person recovery narratives. *Psychiatric Rehabilitation Journal*. 2001; 24(4):335–343. [PubMed: 11406984]
- Schauer C, Everett A, del Vecchio P. Promoting the value and practice of shared decision-making in mental health care. *Psychiatric Rehabilitation Journal*. 2007; 31(1):54–61. [PubMed: 17694716]
- Schinkel, M., Dorrer, N. *Towards Recovery Competencies in Scotland: The Views of Key Stakeholder Groups*. 2007. <http://www.scottishrecovery.net/content/mediaassets/doc/Towards%20recovery%20competencies.pdf>
- Solomon P. Peer support/Peer-provided services underlying processes, benefits and critical ingredients. *Psychiatric Rehabilitation Journal*. 2004; 27(4):392–401. [PubMed: 15222150]
- Sowers W. Transforming systems of care: The American association of community psychiatrists' guidelines for recovery-oriented services. *Community Mental Health Journal*. 2005; 41(6):757–774. [PubMed: 16328588]
- Townsend, W. Unpublished training guide. Jonesboro: WLT Consulting; 2005. *Understanding my recovery process: A consumer's training guide on recovery*.
- Townsend, W., Boyd, S., Griffin, G. *Emerging Best Practices in Mental Health Recovery*. Columbus: Ohio Department of Mental Health; 1999.